Maternal and Child Health Services
Title V Block Grant

State Narrative for Michigan

Application for 2013
Annual Report for 2011

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Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

A copy of the Assurances (non-construction programs) and Certifications may be obtained by contacting the Title V Director's Office at 517-335-8928.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

The draft application was posted on the Department's website. Public input was invited through direct notification via email to advisory groups, local health departments, advocacy groups and other state programs. No comments were received as of this writing. The Department will continue to seek public input through social media throughout the summer.

In addition to soliciting public comment on the application itself, the Department works, on an ongoing basis, without outside entities representing advocates, advisory bodies, providers, and consumers to receive input on aspects of the Title V application through the individual programs and projects. For example, in developing our recent Infant Mortality Reduction Plan, we worked with a steering team consisting of providers from hospitals, local health departments, and research institutions, and representatives from Primary Care Association, Michigan Health and Hospital Association, professional associations, community organizations, Inter-Tribal Council of Michigan, advocacy organizations, Michigan Association of Local Public Health, Michigan Association of Health Plans and the W.K. Kellogg Foundation. The Children's Special Health Care Services program works routinely with parent consultants through the Family Center to provide information and support to families and to receive input on program operations. Other programs work with outside entities on a project basis to receive input on aspects of the program (e.g., redesign of the Maternal and Infant Health Program, development of a regional perinatal system of care - see page 15).

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The assessment of needs for the MCH population for 2011-2016 highlights the continuing need to focus on reducing infant mortality and the associated risk factors. Michigan's infant mortality rate remains above the national rate and significant disparities exist between indicators for the white population and for minority populations. To accomplish reductions in these indicators, a change in approach is necessary. Priorities for the 2011-2016 period will not only focus on the traditional risk factors associated with infant mortality, including low birth weight, preterm birth and unintended pregnancy, but also on the social determinants of health and the patterns of health established during the life course. Strategies will focus on improving the pre-conception and interconception health status of women of child-bearing age, including addressing chronic disease, obesity and domestic violence factors. Increasing the proportion of intended pregnancies, including reducing adolescent pregnancy, will also continue to be an important effort.

In the Fall of 2011, two statewide summits focusing on two of the Governor's Dashboard measures -- obesity and infant mortality -- were held. The infant mortality summit called together state and local policy leaders, public, private and non-profit providers, researchers, payers, and advocacy representatives from across the state. From the summit, seven strategies were recommended to reduce the overall infant mortality rate in Michigan and the disparity in infant mortality rates between racial and ethnic groups: 1) implement a statewide regional perinatal system; 2) promote adoption of "Hard Stop" policies to reduce medically unnecessary deliveries before 39 weeks gestation; 3) promote adoption of progesterone protocol for high risk women; 4) promote safer infant sleeping practices to prevent suffocation; 5) expand home visiting programs to support vulnerable women and infants; 6) support better health status of women and girls; and 7) reduce unintended pregnancies. Underlying these recommended strategies, were several principles: awareness of and attention to the influence of social determinants of health; promotion of the health of women throughout their life; use of clear and consistent messaging; and dedication of resources to support evidence-based policies and programs. In response, the Department, with the assistance of the Infant Mortality Steering Team, developed a three-year plan to address the recommendations from the summit (see attachment). The Steering Team includes the same cross-section of representatives as those attending the summit.

The Department continued to pursue the establishment of a regional perinatal system structure. Five workgroups with representation from all relevant stakeholders were convened to develop recommendations for implementation of the proposed system: Designation/Verification/ Certification; Transport/Triage/Destination; Quality Improvement/Data/Evaluation; Education/Training & Communication; and NICU Follow-up. The workgroups presented their recommendations to the Department in May 2012. Funding for this program was approved in legislation passed in December 2010 that created a regional trauma system. However the amount of funding available from the Crime Victims Compensation is still not known, but the Department will continue to work toward implementation of the system as a key objective within our infant mortality reduction plan.

With a grant from the Kellogg Foundation (PRIME - Practices to Reduce Infant Mortality through Equity), the Department will develop and implement a training curriculum for state staff on multi-culturalism and the effects of racism in areas such as developing a common language, analysis and definition of racism, and understanding the connection of their work to institutional racism. Through this grant, the Department is supporting a PRAMS survey of all American Indian births

using an expanded definition of that group. The survey will be completed in 2013.

Babies born with Newborn Drug Withdrawal Syndrome has been identified as an emerging issue in the state. From 2005 to 2011, the percent of all births with this syndrome increased from 0.14% to 0.60%, mostly in the southeastern area of the state. Through the Michigan Vermont Oxford Network, a coalition of hospitals in the state participating in VON and the Department of Community Health, an iNICQ project is being developed to standardize care, as appropriate, and reduce length of stay in the NICU. The objectives of the project are to: assist multidisciplinary teams at participating hospitals in identifying improvement opportunities and testing and implementing changes designed to achieve improvement; provide a core set of web-based sessions and supporting materials which the state collaborative can build upon to involve all delivery hospitals and payers in improvement; and engage new hospitals in the vision and mission of the Vermont Oxford Network. The project will be funded by the state Medicaid program.

Addressing obesity will continue to be a priority for improving the health status of children and women of child-bearing age. Obesity increases the risk of many diseases and health conditions that affect pregnancy outcomes and children's health status. Obesity disproportionately affects Black residents of Michigan.

In September 2011 a statewide summit on obesity was held to engage stakeholders from across the state in the development of actions to reduce the obesity rates among the population overall and children. From the summit recommendations, the Department developed the "4 X 4 Plan" with the following strategies and goals:

Maintain a healthy diet	Body Mass Index
Engage in regular exercise	Blood Pressure
Get an annual physical examination	Cholesterol level
Avoid all tobacco use and exposure	Blood sugar/glucose level

A. Develop multimedia public awareness campaign to encourage every resident to adopt health as a personal core value through promotion of the 4 X 4 Plan
B. Deploy 46 community coalitions throughout Michigan to support implementation of the 4 X 4 Plan
C. Engage partners throughout Michigan to help coalitions implement the 4 X 4 Plan: employers, trade and other professional organizations; education system; and departments of state government.
D. Within MDCH, create the infrastructure to support 4 X 4 Plan implementation energizing the local coalitions and partners.

Within these strategies, the MCH program will promote the Michigan Model as an effective K-12 health education curriculum and the 4 X 4 Plan among women of childbearing age to improve their health status before, during and between pregnancies.

Childhood lead poisoning prevention is also a continuing environmental priority for the Department, along with asthma and second-hand smoke. While significant improvements in the number of children under age 6 with elevated blood lead levels have been made, there are still pockets of unacceptable rates of lead poisoning and disparity between the rates for white and black children. Asthma continues to be one of the top causes of preventable hospitalizations for children. The prevalence of high school students with asthma is increasing.

The Department is working with the Children's Trust Fund to include the ACE (Adverse Childhood Experiences) module in Michigan's 2013 BRFSS. This module contains questions related to such topics as physical and emotional abuse, substance use in the home, sexual abuse, violence between adults in the home, and incarcerated member of the household that may lead to negative adult health outcomes.

The needs assessment revealed an alarming trend in sexually transmitted diseases among teens, 15-19 years of age. The rates of infection for Chlamydia increased by 257% from 2000 to 2010. Gonorrhea rates have declined in the past two years after peaking in 2008, but still up by 6.6% over 2000 levels. Rates of new HIV diagnoses among 13-19 year-olds stabilized between 2001 and 2010.

Intimate partner and sexual violence has become an increasing concern for youth and pregnant women. Native Americans are disproportionately affected by dating violence and rape. Domestic violence is one of the risk factors associated with maternal depression.

Access to dental care continues to be a priority concern in terms of its availability to adults and children including children with special health care needs, and in terms of the impact of oral health upon the general health of children and pregnant women.

In order to more effectively address the complex needs of CYSHCN, the establishment of a medical home is critical to the coordination of primary and specialty services. Efforts will continue to define and implement the medical home concept for CYSHCN in Michigan. Early intervention and developmental screening services will allow children to develop to their full potential and enhance their learning ability. See NPM #03

In 2011, the CSHCS program implemented a new policy to pay the insurance premiums for the 18 and over population with cystic fibrosis and hemophilia through Michigan's High Risk Pool (HIP Michigan). By paying the premiums for this population, more comprehensive coverage is provided and saves state dollars. See NPM #04.

An attachment is included in this section. IIC - Needs Assessment Summary

III. State Overview

A. Overview

The Title V program in Michigan operates within the larger context of public health services as articulated in the Department of Community Health's mission statement: "...to promote access to the broadest possible range of quality services and supports; take steps to prevent disease, promote wellness and improve quality of life; and strive for the delivery of those services and supports in a fiscally prudent manner." To accomplish this mission, the department employs a variety of resources including federal, state and local funding to provide, arrange or assure access to a broad range of health and other social services. In accordance with the Public Health Code, local health departments are our main partner in fulfilling our Public Health Mission. Services are arranged and delivered at the community level through a variety of public and private agencies, including local health departments, hospitals, clinics, private practices, schools, Planned Parenthood organizations, migrant health centers, and primary care centers. Cooperative efforts to achieve specific initiatives are arranged with the private sector, such as managed care plans, universities, Delta Dental of Michigan, Blue Cross/Blue Shield of Michigan, Michigan State Medical Society, and Michigan Association of Broadcasters. Within the Department of Community Health, Title V programs and planning and policy activities are coordinated with the Medicaid program, MIChild (state CHIP), mental health and substance abuse services, chronic disease programs, communicable disease programs, and injury prevention programs. The Department also works cooperatively with other State departments on issues of mutual responsibility.

The Title V program is operated by the Bureau of Family, Maternal and Child Health. The Title V Director is also the Director of the Bureau. The Bureau includes the Division of Family and Community Health, Children's Special Health Care Services Division, and the WIC Division. The Division of Family and Community Health manages all of the MCH programs besides CSHCN. The Title V Director reports to the Deputy Director for Public Health who reports to the Director of the Department of Community Health (see attached organization chart). The Department of Community Health is composed of five administrations which include Medicaid (Medical Services Administration) and Mental Health and Substance Abuse.

The public health functions of assessment and assurance are shared between the Department of Community Health and local health departments (LHD). Under the Public Health Code, all counties are required to provide for a local health department and are charged with: prevention and control of environmental health hazards; prevention and control of diseases; prevention and control of health problems of particularly vulnerable populations; development of health care facilities and services delivery systems; and regulation of health care facilities and services delivery systems to the extent provided by law. There are 30 single county health departments, 14 district health departments covering multiple counties, and one city health department. See Section III.E below for further discussion of the role of local health departments.
/2013/ Due to a critical financial situation, the Mayor of the City of Detroit has proposed elimination of the city's health department. A proposal to turn over the responsibilities of the city health department to a public nonprofit agency, the Institute for Population Health, effective October 1 2012, has been advanced and is being considered by the City Council. Under the Public Health Code, Detroit is not required to operate a health department. Another option is for Wayne County to take over responsibility for public health activities within Detroit.//2013//

The Title V program also works across state departments on initiatives that affect our mutual customers. The Title V Director serves on the Board of the Children's Trust Fund that serves as a voice for Michigan's children and families and promotes their health, safety, and welfare by funding effective local programs and services that prevent child abuse and neglect. Another inter-agency initiative is the Great Start Initiative which supports a comprehensive early childhood system of care (ECCS). This initiative began with a State Early Childhood Comprehensive

Systems grant from HRSA in 2003 and now serves children and families statewide through local collaborative teams.

According to the U.S. Census Bureau, Michigan's population as of July 1, 2009 was 9,969,727. The state population has remained fairly steady over the past decade, ranging from 9,938,444, according to the April 1, 2000 Census, to a high of 10,090,554 in 2005. Births in Michigan have declined since 2000 by 14.3%. Michigan's rate of net migration to other states was 1.1 % in 2008. From 2000 to 2006, Michigan's out-migration rate was very close to the average for all states, but increased in 2007 and 2008. More than 80% of the state's population resides in the southern half of the Lower Peninsula; almost half of the population resides in southeastern Michigan. Approximately 3.1% of the state's population resides in the Upper Peninsula. About 19% of the state's population resides in rural areas.
/2012/According to the 2010 US Census Report, Michigan was the only state to lose population between 2000 and 2010, experiencing a drop of 0.7%. The City of Detroit was especially impacted, experiencing a drop of approximately 25% in population during the decade. The white, black and Native Hawaiian/Pacific Islander populations declined, while the Native American, Asian, and Hispanic populations increased. The Asian population increased by 34.9% and the Hispanic population increased by 34.7%.//2012//

According to the US Census Bureau, in 2009 Michigan's population was 81.1% white, 14.2% African American, 2.4% Asian/Pacific Islander, 0.6% Native American and 1.6% two or more races. 4.2% of the population was of Hispanic ancestry. The demographic profile of the state indicates significant increases over the last two decades in the percentage of residents that are Asian/Pacific Islander and Hispanic. From 1990 to 2009, the percentage of residents that were Asian/Pacific Islander increased 100%, and the percentage that were Hispanic ancestry increased 90.9%. Over the same time period, the proportion of the population that was white decreased by 3.6% and the proportion that was African American increased by 1.4%. The proportion of the population that was Native American remained the same.

In 2008, 23.9% of the population was under 18 years of age; 36.0% were 18-44 years; 27.1% were 45-64 years; and 13.0% were 65 years and older. From 1999 to 2008, the population under 18 years of age declined by 7.6%, and the population 45 years and older increased by 18.1%. Among the population under 18 years of age, 77.6% were white, 18.6% were Black, 0.9% were Native American, and 2.9% were Asian/Pacific Islander. 6.4% of the population under 18 years of age were Hispanic.

Among people 5 years of age or older, 9% spoke a language other than English at home. 34% of those spoke Spanish and 66% spoke some other language.

According to the Current Population Survey, 2008, 13.0% of the total population was below the federal poverty level, and 19.1% of children under 18 were below poverty level. In 2006-2008, 10.0% of all families and 31.0% of families with a female householder and no husband present had incomes below poverty. During the same three-year period, the median income of households in Michigan was $49,694. For the first half of fiscal year 2009, more than 20% of the population was receiving some form of public assistance benefits. The WIC program serves more than 50% of infants in Michigan.
/2012/The economic difficulties in Michigan continued to place heavy demand on public assistance programs. During FY2010, on average approximately 24% of the state's population received some form of public assistance, a 14% increase over 2009.//2012//
/2013/ Public assistance programs continued to grow in 2011. The monthly average number of recipients grew by 6.4%, representing 26% of the state's total population.//2013//

Michigan's economy has suffered severely over the past two years. According to the U.S. Bureau of Labor Statistics, employment in Michigan in 2008 declined by 3.2%. Payroll jobs in transportation equipment manufacturing decreased by 36.5% from December 2007 through October 2009; durable goods manufacturing declined by 26.4%; and construction by 24.0%. The

2009 average annual unemployment rate was 14.0% compared to the U.S. rate of 9.2%. The unemployment rate reached a peak of 15.3% in September 2009. Job losses have slowed in the state as the economy generally improved and auto industry production resumed, albeit at lower levels. As of May 2010, the Michigan unemployment rate was 13.6% compared to the U.S. rate of 9.7%. Recovery will be slow as Michigan's economy evolves from heavy dependence on the auto industry to a service-based economy.
/2012/Michigan continues with a slow economic recovery. For May 2011, the unemployment rate in Michigan was 10.3% compared to a US rate of 9.1%.//2012//
/2013/ The jobless rate in Michigan cotinued to decline in Michigan, falling to 8.3% in April 2012.//2013//

Due to the manufacturing history of Michigan and the strong presence of unions, the state has enjoyed a relatively high proportion of the population that was insured. However, with the decline of the auto industry and the general economic downturn, the number of uninsured residents is increasing. Overall, the uninsured population in Michigan increased from 1.04 million in 2006 to 1.15 million in 2007. Although Michigan had one of the lowest uninsured rates for children, a 2009 report by the Center for Healthcare Research and Transformation indicated that the percent of uninsured children (0-18 years of age) increased from 4.7% in 2006 to 6.2% in 2007, and the percent of uninsured young children (0-5 years) increased from 4.6% to 7.8% during the same period. African Americans and Hispanics were disproportionately represented in the uninsured population.
/2012/During FY 2010, an average of 1,862,261 persons received Medicaid benefits, an increase of 9% over 2009. According to Kaiser Family Foundation State Health Facts, coverage of children 0-18 by employer-sponsored insurance declined by 2.1% between 2007 and 2009, by individual insurance declined by 0.5%, and by Medicaid increased by 3.4%. Among all persons ages 0-64, coverage by employer-sponsored insurance decreased by 4.5% between 2007 and 2009, by individual insurance increased by 0.1%, and by Medicaid increased 2.3%.//2012//
/2013/ The average monthly number of Medicaid recipients increased by 3.8% from 2010 to 2011. The average monthly number of children under age 21 receiving Medicaid benefits increased by 10.3%. According to the Kaiser Family Foundation State Health Facts, employer-sponsored health insurance coverage declined by 3.6% for persons 0-64 years of age, and by 3.8% for children under age 21. Individual insurance coverage increased by 0.5% for persons 0-64, while individual coverage for children under age 21 decreased by 0.4%.//2013//

Distribution of health care resources is a significant factor in accessing health care. According to Michigan Strategic Opportunities for Rural Health Improvement: A State Rural Health Plan, 57 of the 83 counties in Michigan are defined as rural, containing 19% of the state's population. Rural Michigan has 165 physicians per 100,000 population, compared to 272.9 physicians per 100,000 population for the state as a whole. Two-thirds of the hospitals in Michigan are in metropolitan counties, and 40% are located in southeastern Michigan. Most of the specialty care for children is located in the southern portion of the lower peninsula of the state.
/2012/In 2010, two more hospitals in the northern portion of the Lower Peninsula closed their delivery units, bringing the total of contiguous counties without OB services to 16. This is a largely rural area. The issues cited were lack of service profitability, inability to recruit and retain qualified physicians, low Medicaid reimbursement levels and malpractice costs. Additionally, pediatricians have been leaving the area. A group of representatives from area hospitals, local and state health departments and provider organizations have been meeting to research solutions to this problem.//2012//

The leading causes of death for infants under age 1 in 2008 were certain conditions originating in the perinatal period, congenital malformations, accidents, SIDS and homicide. Black infants died at 2.7 times the rate of white infants; Hispanic infants at 1.6 times the rate for whites; and American Indian infants at 1.5 times the white rate. The five-year (2004-2008) average low birth weight rate (8.4) increased over the preceding five-year period (8.0). Black infants were more than twice as likely to have low birth weight as white infants. The pre-term birth rate was relatively

unchanged from 2003 to 2008.
/2013/ The overall Infant mortality rate declined to 7.1 per 1,000 live births in 2010. Although the percentage of preterm births also declined, the low birth weight rate was unchanged. Disparities persisted between black (14.1) and white (5.5) infant mortality rates and between American Indian (10.5) and white infant mortality rates.//2013//

The overall infant mortality rate in Michigan in 2008 was 7.4. Of the 83 counties in Michigan, eleven counties had a higher infant mortality rate than the state rate -- Berrien (7.8), Calhoun (7.9), Genesee (8.1), Grand Traverse (8.2), Kent (7.5), Lenawee (9.6), Mecosta (20.5), Saginaw (10.2), Saint Joseph (11.0), VanBuren (10.2), and Wayne (10.7)

Among cities with populations greater than 40,000 and more than 200 average number of births, the following cities had the highest average rate of infant mortality in the state in 2008:

Detroit -	14.9	
Pontiac -		13.3
Saginaw -		12.7
Flint -	11.8	
Southfield -	11.5	
Wyoming -	10.1	
Taylor -	9.4	
Grand Rapids -	8.7	
Lansing -		8.5
Battle Creek -	8.0	

Wayne County (including Detroit), Genesee County (including Flint), and Saginaw County had the highest rates of low birth weight.

The Department's focus for addressing infant mortality over the next several years will be on improving the health of mothers, pre- and post-pregnancy. Programs to address chronic conditions, such as diabetes and obesity, will be pursued. Of the live births in 2008, 15.9% of mothers were exposed to second-hand smoke at home, 27.5% of mothers with singleton births had a body mass index above 29.0, 0.8% had pre-pregnancy diabetes, 3.8% had gestational diabetes, 1.2% had pre-pregnancy hypertension, and 4.4% had gestational hypertension. American Indian mothers had the highest rate of exposure to second-hand smoke. Asian/Pacific Islander mothers had the lowest rate of BMI greater than 29.0, but had the highest rate of gestational diabetes.
/2013/ A statewide summit on infant mortality was held in October 2011. From the summit, seven strategies were recommended to reduce the overall infant mortality rate in Michigan and the disparity in infant mortality rates between racial and ethnic groups: 1) implement a statewide regional perinatal system; 2) promote adoption of "Hard Stop" policies to reduce medically unnecessary deliveries before 39 weeks gestation; 3) promote adoption of progesterone protocol for high risk women; 4) promote safer infant sleeping practices to prevent suffocation; 5) expand home visiting programs to support vulnerable women and infants; 6) support better health status of women and girls; and 7) reduce unintended pregnancies.

In September 2011 a statewide summit on obesity was held to engage stakeholders from across the state in the development of actions to reduce the obesity rates among the population overall and children. From the summit recommendations, the Department developed the "4 X 4 Plan" with the following strategies and goals:

Maintain a healthy diet	***Body Mass Index***
Engage in regular exercise	***Blood Pressure***
Get an annual physical examination	***Cholesterol level***
Avoid all tobacco use and exposure	***Blood sugar/glucose level***

A. Develop multimedia public awareness campaign to encourage every resident to

adopt health as a personal core value through promotion of the 4 X 4 Plan
B. Deploy 46 community coalitions throughout Michigan to support implementation of the 4 X 4 Plan
C. Engage partners throughout Michigan to help coalitions implement the 4 X 4 Plan: employers, trade and other professional organizations; education system; and departments of state government.
D. Within MDCH, create the infrastructure to support 4 X 4 Plan implementation energizing the local coalitions and partners.//2013//

According to the County Health Rankings for Michigan , the following counties had the best rankings in both Health Outcomes and Health Factors: Livingston (central Lower Peninsula), Ottawa (southwestern Lower Peninsula), Leelenau (northern Lower Peninsula), Clinton (central Lower Peninsula), Washtenaw (southeastern Lower Peninsula), Grand Traverse (northern Lower Peninsula) and Marquette (Upper Peninsula). The only major city (population > 40,000) in this area is Ann Arbor (Washtenaw County).

The counties with the worst rankings in both categories were: Saginaw (central Lower Peninsula), Calhoun (southern Lower Peninsula), Gladwin (central Lower Peninsula), Genesee (central Lower Peninsula), Lake (northern Lower Peninsula), Wayne (southeastern Lower Peninsula) and Clare (northern Lower Peninsula).

The leading causes of death among children ages 1-19 in 2008 were accidents, assault (homicide), cancer, suicide and congenital malformations. The leading causes of hospitalizations for children were females with deliveries, injury and poisoning, asthma, pneumonia and appendicitis. Births to teens aged 15 to 17 years declined from 2004 (18.7%) to 2007 (14.0%), but then increased significantly in 2008 (18.2%).

B. Agency Capacity

The Division of Family and Community Health (DFCH) is responsible for assessing need, recommending policy, developing and promoting best practices and service models, and advocating for the development of capacity within communities to provide quality, accessible, culturally competent services. We focus on improving the health, well-being, functioning and/or quality of life for infants, children, adolescents, women of childbearing age, and their families. Maternal and child health programs, policy development and activities focus on assessment of health status, identification of priority health issues, and development and support of health care programs and systems to address these health issues in the context of health care reform and with culturally competent approaches to service delivery.

The life-course framework is the structural model for the organization of the division and its strategic plans to address the needs of the population served to meet the department's mission "to protect, preserve and promote health with special attention to the needs of the vulunerable and underserved." The division's organizational unit structures are based on life stages: reproductive/preconception/interconception, maternal/interconception, infant, child, adolescent and family (oral health -- crossing all life stages). The division continuously supports linkage to the adjacent life phase of which each individual grows and develops with the impact of the complex interplay of the social determinants of health.

The health of a woman prior to pregnancy has a significant impact on pregnancy outcome and the early health of the infant sometimes more than interventions during pregnancy. Priority is being placed on increasing health promotion and prevention activities including strategies to increase access to effective social-emotional, medical and dental health for women. Mental health service availablity and improvement of social determinants of health are addressed as a

component of improving the overall health of women. Interconception care is a subset of preconception care, comprised of interventions that aim to identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management, emphasizing those factors which must be acted on before conception or early in pregnancy to have maximum impact. It is more than a single visit and less than all well-woman care.
/2012/ The department also promotes and supports the concept and model of family centered medical home for all pregnant women, infants and children. //2012//

For all the life course stages we connect to and work with other organizational units of the Department and
community partners who may be technical experts and/or are responsible for oversight of assessment, strategic planning and implementation of care systems and policies for other health care and/or social determinates of health (mental health; substance abuse; child development; early, middle and adolescent education; chronic disease development; healthy environments, etc.). Each unit within the DFCH addresses these factors, concentrating on the portion of the life course they are responsible for, but also by building on, coordinating and complementing the other life course stage immediately adjacent or relevant.

To support relevant and culturally sensitive planning efforts, the division uses advisory groups; develops and holds work groups of diverse representatives; conducts focus groups; and supports, employs or contracts for ongoing parent or population representatives to have ongoing or episodic input into the planning and sometimes the monitoring process of our efforts. In addition, all managers have as a performance objective to value and secure a diverse work environment that ensures compliance with equal opportunity in hiring, training and assignments to assure diversity in the views brought to bear in our operations.

During the last year and a half there have been conducted division-wide cultural sensitivity trainings and the division's director and section managers have participated in cultural sensitivity trainings. One of our intents is to improve all staff's awareness for the need to gather and monitor appropriate data on the diversity of the state's population and the disparity in the health statistics in each life course stage. There are multiple representatives working on the Department's Health Disparities Work group. Some of this group's charges are to increase awareness of health disparity, and collect and disseminate relevant data to distribute information focusing on eliminating disparities and ensuring policies, programs, and implementing strategies that are culturally and linguistically tailored to reduce morbidity and mortality.

The Reproductive Health Unit is responsible for preconception and interconception health planning and promotion. The primary service area is the delivery of quality, equitable, scientifically safe contraception and reproductive health care services via the implementation of the Federal Title X Family Planning program. As the long-term single, state-wide grantee for Title X Federal funds, the Family Planning Program makes available general reproductive health assessment, comprehensive contraceptive services, related health education and counseling, and referrals as needed to Michigan residents. Services are available to anyone, but the primary target population is low-income women and men. Following Title X regulations services are delivered through a statewide network of local health departments, Planned Parenthood affiliates, hospitals and private non-profit agencies.

Michigan Department of Community Health (MDCH) received approval of its Mediciad Section 1115 Family Planning Waiver July 1, 2006, expanding Medicaid supported family planning services to women 19-44 years old with family incomes up to 185% of the Federal Poverty Level. The approved service cap is 200,000 women. MDCH is currently in the process of completing a continuation application for the Family Planning waiver, due in 2011.
/2012/ MDCH was granted an extension for the waiver by Centers for Medicare and Medicaid Services and is currently working to meet that deadline. //2012//

Other important focus areas of the Reproductive Health Unit are: promotion of "Prevention of Unintended Pregnancy in Adults 18 and Older" care recommendations, Maternal Child Health hotline oversight, prenatal smoking cessation promotion and training, and coordination with statewide sexually transmitted infection reduction efforts.
/2013/ MDCH is currently working under the waiver extension granted by Centers for Medicare and Medicaid Services. MDCH has applied for a Medicaid State Plan Amendment to expand Medicaid supported family planning and related services to men and women of child-bearing age up to 185% of the Federal Poverty Level.
Under the paragraph, "Other important focus areas of the Reproductive Health unit are: promotion of "Prevention of Unintended Pregnancy in Adults 18 and Older" care recommendations" add: "and Medicaid Administrative Outreach." //2013//

The Perinatal Health Unit is the area within DFCH that is responsible for program activities, health promotion and prevention that focuses on the woman who is pregnant, between pregnancies and their newborn infant. The Perinatal Health Unit has the following objectives that guide their activities: increase the interconception health of women including prenatal and postnatal; reduce infant mortality and morbidity; reduce maternal mortality and morbidity; eliminate disparities in infant and maternal birth outcomes; implement, support and evaluate a system of perinatal regionalization; increase the development of a medical home for women, particularly of child-bearing age; reduce untreated maternal depression; increase maternal/infant attachment for all women who give birth in Michigan; increase successful maternal health management for both women and their infants, including effective engagement in appropriate services and supports, particularly for women identified as being at-risk due to social/economic determinants of health; and increase screening for maternal alcohol use and implement prevention strategies to decrease the number of women who drink alcohol during pregnancy.

These objectives are accomplished by the provision of organized program, services and prevention activities. The following programs & services are coordinated within the Unit and incorporate culturally competent approaches:

Fetal Alcohol Spectrum Disorders (FASD) program provides prevention, awareness and access to services by: multidisciplinary teams called Centers of Excellence that diagnose children and provide initial care planning; community projects that provide local prevention and linking to services projects; and training and consultation that assist these agencies in their work. The outcome is to decrease this preventable disorder and enhance the quality of life for affected individuals /their families and lessen the social and economic impact of FASD in Michigan. Infant Mortality and Morbidity activities are designed for prevention and reduction of infant mortality/morbidity and elimination of racial disparities in infant death rates. The creation and implementation of the MDCH Infant Mortality Strategic Plan will help drive this process.
/2013/ In October 2011 an Infant Mortality Summit was held and seven priorities were developed from stakeholders input: Safe Sleep, Elimination of non medically indicated deliveries prior to 39 weeks, home visitation, unintended pregnancies, health disparities, progesterone protocol and perinatal regionalization. //2013//

Local Maternal and Child Health funds are flexible funds from the Federal Title V Maternal and Child Health Block Grant that are made available to local health departments to address locally identified health needs of women and children in their jurisdictions. Each local health department uses both a defined needs assessment process to determine/identify their MCH needs and also identifies which of the 18 priority MCH measures established by the MCH Bureau of the Department of Health and Human Services and eight/2012/ ten//2012// measures established by MDCH that their plan addresses.

Michigan Maternal Mortality Surveillance is a program of case ascertainment, surveillance of maternal death data and trends, case reviews and development of prevention recommendations based on analysis of data and case review findings to reduce Michigan's maternal deaths, illness and complications and decrease the black/white mortality ratio.

/2012/ Expected outcomes include: development of public health prevention recommendations that address health care policy; system change, and social and environmental conditions that will reduce Michigan maternal mortality and eliminate racial disparities in maternal death rates. //2012// ***/2013/ MMMS program completed a database which will allow vital records prepopulation by 10/2012. //2013//***

Maternal and Infant Health Program provides case management and support services to pregnant women and infants enrolled in Medicaid to improve maternal and infant birth outcomes. /2012/ MIHP "redesign' continues in an effort to become an evidence based model. The program utilizes a standardized population management, care coordination approach with standards for adherence to model fidelity, streamlined paperwork & research based data collection. Quality assurance measures are in place to assure that services are consistently implemented in the varied programs throughout the state. //2012//
/2013/ Quasi experimental study to be concluded with report submitted by September 2012. //2013//

Medicaid Outreach/Access to Health Care allows for Federal match available to local health departments to support their local activities to facilitate outreach, public awareness, enrollment, access, monitoring and referrals for Medicaid services.

The Perinatal Health Unit has identified resources and methods to establish a formal perinatal care system as recommended by the Perinatal Regionalization Workgroup consistent with evidence based guidelines to clearly define levels of care designations and collaboration among regional hospitals providing services to women, neonates/infants and families to improve pregnancy outcomes. A nurse was recently hired to assume some of thes tasks required. The Unit collaborates and coordinates with many different groups to provide these services including: other State Departments; other Divisions within the Department of Community Health; local health departments; schools of medicine and public health; professional medical organizations; state wide organizations; hospitals; clinics; FQHCs; physicians; advocacy groups; culturally diverse community groups and interested stakeholders.
/2012/ MDCH is moving forward with plans for perinatal regionalization. Two pilot projects and a designation survey for birth hospitals are in progress. The nurse consultant is assessing high risk birth hospital protocols. MDCH is a catalyst to create OB services in underserved portions of Michigan. //2012// ***/2013/ Five workgroups from September statewide meeting presented recommendations May 2012 for initiating Perinatal System of Care. Next step is hospital consensus and drafting of administrative rules. //2013//***

The Infant Health Unit is responsible for infant health promotion program & initiatives with objectives to:
Reduce fetal and infant deaths
Reduce racial disparity in infant mortality
Increase the percentage of infants sleeping in safe environments
Increase the proportion of mothers who breastfeed their babies and increase lactation period
Increase the percentage of employers who have worksite lactation programs
/2012/ There are no longer Infant Health Unit program initiatives for lactation. //2012//
Promote "Routine preventive services for infants & children birth - 2 months
Promote screening and evidence based treatment for known chronic conditions in newborns
Increase the proportion of newborns that receive hearing screens no later than 1 month of age, audiologic evaluation no later than three months, and intervention services no later than six months
Increase early identification of physical, developmental and social-emotional issues and early linkage to appropriate follow up interventions

Programs services and initiatives in the unit are:

The Early Hearing Detection and Intervention program is a process of screening, diagnosis, and

intervention for newborns with congenital hearing loss. Universal newborn hearing screening is hospital-based aligned with efforts to establish and maintain a local comprehensive community-based system that provides screening, diagnosis and intervention services by the age of six months for infants who have been identified as having a potential hearing loss. The department provides education to local health care facilities on the importance of newborn hearing screening, the need for a collaborative local team for infants requiring follow-up, and maintains a statewide database for tracking screening and follow-up activities. Michigan Hands & Voices and the Guide By Your Side program, which provide support, resources and activities to families with a child who has hearing loss, are also supported under this program.

The Safe Delivery program, by state law, allows for anonymous surrender of an infant (within 72 hours of birth) to an Emergency Service Provider without the expressed intent to return for the newborn, per the Michigan Safe Delivery of Newborns Act. A toll-free hotline exists to provide information to the public regarding the law, resources for counseling and medical services, and information on adoption services.

Infant Death Prevention and Bereavement services are provided through a contract with the nonprofit agency Tomorrow's Child. Tomorrow's Child develops and promotes initiatives for human service professionals that work with high-risk families; and develops bereavement counseling, education, advocacy and support services for families who have experienced the death of a young child. These services are promoted to medical examiners, hospitals, local health departments, FIMR teams and local child death review teams. Tomorrow's Child also provides promotion, education, and publication distribution regarding infant safe sleep under this agreement.

The Infant Safe Sleep State Advisory Team is a public/private partnership that coordinates statewide efforts to implement Infant Safe Sleep and reduce infant deaths related to unsafe sleep environments. The Team includes representatives from the Department of Community Health, Department of Education, Department of Human Services, Michigan Public Health Institute and Tomorrow's Child. Formed in 2004 the Team works diligently to develop a statewide, consistent, comprehensive message and strategy to inform families and caregivers about unsafe sleep. An Infant Safe Sleep website was established, as well as an online training module.

The Infant Death Autopsy Reimbursement program provides financial incentive to local medical examiner's systems to perform autopsy as well as death scene investigation in cases of Sudden Unexpected Infant Death. This program also provides surveillance of preventable infant deaths, especially post-neonatal and sleep-related deaths. Program objectives include the reduction of infant mortality by correctly identifying cause, manner and significant risk factors contributing to infant death, and standardization of how medical examiners certify cause and manner of SUID.

Michigan's Fetal Infant Mortality Review (FIMR) program identifies and examines factors that contribute to fetal and infant deaths through the systematic evaluation of individual cases. Multidisciplinary teams throughout the state work together to find patterns of need in a community and gaps in the perinatal health delivery system. The state FIMR coordinator provides technical assistance, consultation, and training of local teams. A single, state supported data system serves the teams.
/2012/ A CDC funded FIMR HIV Prevention Methodology project began in 2011. The project adapts the FIMR model to study cases of HIV + women who give birth in Michigan, for the purpose of identifying missed opportunities for preventing mother-to-child transmission of HIV. //2012// ***/2013/ The Infant Safe Sleep Advisory Team now includes the Children's Trust Fund (CTF) and Michigan Council for Maternal Child Health (MCMCH) as member agencies. A Request For Proposals (RFP) process will be conducted to select the contractor for Infant Death Prevention and Bereavement services in 2012. //2013//***

The Child Health Unit's purpose is to administer programs and initiatives that improve child wellness across all domains of development; increase family ability to understand and promote

their child's wellness; support the development of an integrated and comprehensive early childhood system that spans public/private organizations and includes promotion, prevention, and intervention activities; and collect and analyze data to improve systems and service outcomes.

Programs and initiatives supported within the unit include preschool and school-aged Hearing and Vision Screening programs; Childhood Lead Poisoning Prevention; the Parent Leadership in State Government parent training initiative; and Project LAUNCH. The unit serves as liaison between Public Health and Part C/Early On Michigan which is administered out of our state Department of Education; interagency efforts to reduce abuse and neglect with our Children's Trust Fund and Department of Human Services; and with the MDCH Medical Services Administration and Michigan AAP regarding implementation of EPSDT. The unit also collaborates with both internal and external partners on initiatives to improve early childhood systems coordination, improve and expand home visitation services, /2012/ and the infrastructure to support such services, //2012// implement evidence-based practices and measure fidelity, support the integration of social-emotional well-being as a component of child wellness; expand developmental screening; and increase the flow of information to the public that can support family and child wellness.
/2013/ In the past year, the Unit has added responsibility for leading the Michigan Maternal, Infant and Early Childhood Home Visiting Program and its system infrastructure building efforts, as well as a Primary Care Developmental Screening project. Both projects involve extensive collaboration with other internal and external partners, and represent significant opportunities to impact improvements in children's health and wellness in Michigan. //2013//

The Adolescent and School Health (ASH) Unit has a strong foundation in addressing a range of adolescent and school health issues through direct services and programming. Among the multiple adolescent health-focused programs coordinated by this unit are: Child and Adolescent Health Centers (school based health centers), Michigan Model for Health K-12 Comprehensive School Health Curriculum, the School Wellness Program (school nursing and mental health), a comprehensive Teen Pregnancy Prevention Initiative and Coordinated School Health Programs (in collaboration with the Michigan Department of Education).

The mission of the ASH Unit is to improve the health and well-being of Michigan's school-aged youth and young adults. The vision for ASH is that school-aged youth and young adults will transition into adulthood physically, emotionally and socially healthy; equipped with the necessary knowledge and skills to make informed decisions regarding their health and well-being; and able to locate resources and be active consumers in their health. ASH has many core objectives that guide its work, including:
- Supporting parents in understanding adolescent health issues;
- Improving access to care and a medical home for adolescents and young adults;
- Providing all children and youth with medically accurate information and best practices around health promotion and skill development;
- Improving access to mental health information, services and supports;
- Promoting healthy and informed decision-making around sexual health, including preconception health; and
- Supporting the identification of health, developmental and social/emotional concerns, through an integrated adolescent system of care at both the state and local levels.

To achieve some of these objectives, ASH operates the following statewide initiatives aimed at school aged youth:
- Child & Adolescent Health Centers are designed for school aged children and youth 5 through 21 years of age. These centers provide comprehensive primary care services, health education, peer counseling, screening/case finding services, referral for specialty care, and Medicaid outreach activities across 69 /2012/ 72//2012// ***/2013/ 69//2013//*** locations in Michigan.

Michigan Model for Health is a nationally acclaimed comprehensive school health education

program that facilitates skills-based learning through lessons that include a variety of teaching and learning techniques, skill development and practice, and building positive lifestyle behaviors in students and families.
- Teen Pregnancy Prevention Initiative is a comprehensive pregnancy prevention program, whose goal is to reduce teen pregnancy in MI through the implementation of the evidence-based program, Safer Choices, in eight high need communities.
/2012/ -The Michigan Abstinence Program promotes abstinence from sexual activity and risky behaviors by providing relevant interventions that build peer pressure skills and promote personal respect and responsibility.
-Taking Pride in Prevention uses evidence-based models to educate adolescents on abstinence and contraception to prevent pregnancy and sexually transmitted infections. The programs must address healthy relationships, adolescent development and parent-child communication. //2012//

- Coordinated School Health Programs, in collaboration with the Michigan Department of Education, support an eight component model within the school district that includes school health, health education, physical education, health services, staff wellness, family and community involvement, healthy school environment, nutrition services, and counseling, psychology and social services.

The ASH unit has many strong collaborative partners at both the state and local level. However one unique partnership has developed with the Michigan Department of Education's Coordinated School Health and Safety Programs Unit. Because both Department's have an enduring commitment to the importance of adolescent well-being particularly when it comes to mental health and promoting social/emotional health, the Departments have created a "shared" state-level public health consultant position to focus exclusively on improving the social/emotional health of school aged youth in Michigan. This is just one example of this unique partnership between the MDCH and MDE.

The Oral Health Program within the division is responsible for education, promotion and implementation of activities and improving oral health throughout the life span for Michigan residents through prevention. Improving access to oral health includes oral health education, prevention of dental disease and dental restorative treatment. Through the efforts of the Oral Health Program, community water fluoridation programs are monitored for safety and effectiveness in reducing dental disease. Fluoride varnish programs and sealant programs offer oral health surveillance on all age children by detecting oral disease, applying preventive treatments, and referring for continued oral care. With the Count Your Smiles and Senior Smiles data collection we will better understand the oral health needs of school children and aging adults. Educating the public, medical and dental professionals as well as collaborating with other sections of the department in oral health has spread the word that oral health is integral to overall health.

Dental Hygiene PA 161 Program Allows a dental hygienist to work under relaxed supervision rules to provide service to the underserved children and elderly populations; must be a local, state or federal grantee health agency for patients who are not assigned by a dentist.

Oral Health Education and Access Promotion is a statewide oral health education program designed to change behavior, create awareness and improve the oral health of persons through all stages of life by linking oral health to total body health.

Points of Light Oral Health Program supports the matching of a dentist with a pediatrician to provide dental care to infants by age one. Educating the physician to do a caries risk assessment, provide anticipatory guidance and early dental interventions can greatly reduce dental disease in this young population.

Dental Treatment for Developmentally Disabled provides limited funding to assist the severe developmentally disabled population to access dental services; clients accepted for funding is

through referral basis only from client case managers.

SMILE! Michigan Dental Sealant Program is a preventive dental sealant program offered to limited 2nd and 6th graders in schools with a high percentage of children enrolled in the Free and Reduced School Lunch Program. The program included an oral screening, placement of dental sealants on all erupted molar teeth, fluoride application, oral health education and referral for dental care.
/2012/ The school-based sealant program is now called SEAL! Michigan. The program expanded to an additional 15 schools for the past year. Another grantee in the Upper Peninsula was awarded a planning grant with implementation for the coming year. Continue discussions and planning to incorporate oral health as a component of the patient-centered medical home and health home grant opportunities. //2012//

Varnish! Michigan Program promotes fluoride varnish programs to reduce incidence of dental decay in primary teeth. Services are available to low income, high-risk 0-5 age children in medical facilities, Head Start and other vulnerable groups. Training on Infant/Child Oral Health is provided for MI Medicaid providers.

Volunteer Dental Program (Donated Dental) is a network of volunteer dentists providing dental care to persons who are mentally and physically handicapped, who are medically compromised, or who are elderly and/or indigent.

The Oral Health Unit collaborates and coordinates with many groups to provide these services including: other state departments; other divisions within the Department; professional medical organizations; state wide organizations; clinics; dentists; advocacy groups; Schools of Dentistry; culturally diverse community groups and interested stakeholders; hospitals; Federally Qualified Health Centers; schools; universities; health insurance plans; and pharmaceutical companies.

Services for Children with Special Health Care Needs

The Michigan Public Health Code, Public Act 368 of 1978 as amended, defines a CSHCS-eligible person as someone under age 21 "...whose activity is or may become so restricted by disease or deformity as to reduce the individual's normal capacity for education and self-support." Persons over age 21 with cystic fibrosis or hereditary coagulation defects (e.g., hemophilia) also may be eligible for services. CSHCS covers chronic physical conditions that require care by medical or surgical specialists. The program also evaluates severity, chronicity and the need to be seen at least once annually by an appropriate pediatric sub-specialist in making a medical eligibility determination. The full range of CSHCS program elements and services includes: case-finding; application for CSHCS coverage, assessment of family service needs, service coordination/case management, specialty medical care and treatment; family support services and opportunities for parent participation in policy development; and specialized home care supports.

The medical care and treatment covered by CSHCS includes a wide range of services such as physician specialist care, hospitalization, pharmaceuticals, special therapies, durable medical equipment, respite, and orthotics/prosthetics. In addition to making payment for these services, CSHCS assures quality in the services provided. Physicians, hospitals, and clinics must meet established criteria in order to qualify as CSHCS "approved" providers. The criteria focus on the demonstration of expertise and willingness to provide pediatric specialty services. Along with the approval of providers, CSHCS authorizes specific providers for each child, so that specialty expertise is appropriate for the child's condition. Provider reimbursement policies and rates are the same for both CSHCS and Medicaid.

The payment agreement fee schedule has been changed to include all clients in a payment agreement on a sliding scale unless they have Medicaid, MIChild (CHIP) or WIC coverage if they choose to join CSHCS. This is a change from having those whose income is at or below 200% of

the federal poverty level or for children adopted with a qualifying pre-existing condition being exempt from a payment agreement. /2012/ The payment agreement exemption for those who qualify for WIC was removed. All clients are now in a payment agreement unless they have Medicaid or MiChild (CHIP). //2012//

CSHCS is a statewide program, although certain program components may not be located in every county. For example, children's multidisciplinary clinics are associated with tertiary care centers, and family support coordinators may serve more than one county. Local health departments (LHDs) serve as a community resource to assist families in accessing needed services, both from CSHCS and other local agencies. LHD CSHCS professionals are encouraged to work closely with their MCH colleagues and with other agencies to identify community service needs from the perspective of children with special health needs and their families. These local collaborative efforts are supported by the state-level approach to community needs assessment and are reflected in efforts to remove artificial, categorical barriers to services. Local efforts are focused on the earliest intervention possible to prevent, cure or minimize the impact of handicapping conditions on children. In addition to program representation activities for the purpose of case-finding, the LHD system, the CSHCS Customer Support Section or the Family Center helps families to obtain needed program information and services. Families are offered a Family Service Needs Summary by the LHD when the family requests assistance in understanding the CSHCS program and other services available in their communities. During the service needs summary, LHD professionals help to identify the needs of all family members. Service coordination can then be provided if the family decides it wants further help in developing self-advocacy skills, problem-solving, or in obtaining needed services.

The Family Center has parent consultants on staff and payroll to work closely with CSHCS, and provides parent membership in the CSHCS Advisory Committee, and the Family Support Network to reinforce family-centeredness. The CSHCS program operates according to the philosophies inherent in Family-Centered, Community-Based, Culturally Competent, Coordinated Care. This philosophy has been incorporated into all CSHCS strategies for program and policy development, and into the service delivery structure. CSHCS has built an infrastructure that assures both input and feedback with regard to these critical program characteristics. Formal relationships with local health departments, initiatives to strengthen home-based care, and provider standards all support a community-based approach. Coordinated care is facilitated by state-level inter-agency planning (including coordination among state-level parent support initiatives); local relationships among and between other MCH colleagues and human service agency professionals; broad representation on the CSHCS Advisory Committee; and expectations of specialty clinic providers, primary care physicians, and local health department professionals.

The CSHCS strategic planning meeting that engaged stakeholders in the process of preparing a five-year plan for the CSHCS program to address the implementation of the MCHB Healthy People 2010 objectives resulted in the establishment of workgroups to begin to address the priorities that the strategic planning meeting identified. (See Needs Assessment, page 13.)

The Family Center has three major areas of responsibility: 1) development of a statewide, community-based network of parent-to-parent support, 2) provision of parental input to CSHCS administration regarding programs and policies; and 3) facilitation of timely responses to families in need. As a core component of the CSHCS organization, the program is headed by a parent of a child with special health needs. The program is unique in that it is inclusive of all families of children with special health care needs, whether or not they are enrolled in CSHCS. The Children's Special Health Care Services hotline is operated through the Family Center.

All children eligible for SSI are also eligible for Medicaid in Michigan. Therefore rehabilitation services are typically provided under Title XIX, often in the school under Medicaid-Reimbursed School-Based Services. Michigan Medicaid has a very extensive benefit package, and the need for further coverage would be rare. CSHCS provides medical services as needed based upon the

CSHCS qualifying diagnosis. Therefore, CSHCS would provide medically necessary services not covered under Title XIX for children enrolled in CSHCS.

C. Organizational Structure

The Title V program is administered by the Bureau of Family, Maternal and Child Health, Public Health Administration, Michigan Department of Community Health. The Bureau includes Divisions of Family and Community Health, WIC, and Children with Special Health Care Services. The Title V Director is the Director of the Bureau who reports to the Director of the Public Health Administration. The Public Health Administration also includes the Bureau of Epidemiology, the Bureau of Health Promotion and Disease Control and the Bureau of Laboratories. The Bureau of Epidemiology maintains the state's vital records system and provides the Title V program with data and analytical support. The Department of Community Health reports directly to the Governor.

The Division of Family and Community Health manages programs within the areas of reproductive health, perinatal health, infant health, child health, adolescent and school health and oral health. This includes Family Planning, Prenatal Smoking Cessation, Fetal Alcohol Syndrome Prevention, Infant Mortality and Morbidity, Maternal Mortality and Morbidity, Maternal and Infant Health Program, Pre/Interconception Health, Local Maternal & Child Health, Early Hearing Detection & Intervention, Medicaid Outreach/Access to Health Care, Safe Delivery, Safe Sleep, Fetal Infant Mortality Review, Child Lead Poisoning Prevention, Early On, Hearing Screening, Vision, Screening, Parent Leadership in State Government, Child & Adolescent Health Centers, Coordianted School Health, Michigan Model for Health, Teen Pregnancy Prevention Initiative, Michigan Abstinence Program, and Oral Health.

Because the WIC program reaches so many low-income families, it is integral to many of our MCH efforts including promotion of immunization, lead poisoning screening, nutrition and breastfeeding. More than half of the infants in the state are seved by the WIC program.

Children's Special Health Care Services provides medical care and treatment, care coordination, case-finding, assessment of family service needs, family support services and other ancillary services for children with special health care needs and works closely with the Medical Services Administration in providing specialty services for Medicaid-eligible families and coordinating with primary care services.
An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

The department does not provide direct services, but contracts with local health departments and other community health agencies to provide MCH services. Local health departments are units of local government. The 45 local health departments in Michigan employ over 5,500 staff including nurses, physicians, nutritionists, social workers, sanitarians, health educators and epidemiologists. Department staff provide training, consultation and technical assistance to local health departments and other community providers in various programs, certify providers of the Maternal and Infant Health Program, determine eligibility for CSHCS program, plan and develop programs, projects and new initiatives, and monitor the performance of local programs. Most of the staff at the state level working on maternal and child health programs are located in the Bureau of Family, Maternal and Child Health which includes the Divisions of Family and Community Health, WIC, and Children's Special Health Care Services. The Bureau Office has two professional and one clerical position. The Bureau is part of the Public Health Administration within the state Department of Community Health. All state staff are located centrally in Lansing.

Alethia Carr is the Title V Director and Director of the Bureau of Family, Maternal and Child Health. Ms. Carr has an MBA and a Bachelor of Science degree in hospital dietetics and is a

registered Dietitian. She has ten years experience as a clinician and more than 25 years of management experience in various maternal and child health programs including childhood lead poisoning, MCH HIV/AIDS, and Women's and Reproductive Health.

In the Division of Family and Community Health, there are 56 established positions including four vacancies. In addition there are fourteen professional contractual staff working on numerous programs and projects. Professional staff is composed of nurses, public health consultants, hearing and vision consultants, nutrition consultant and managers. Brenda Fink, A.C.S.W., is the Director of the Division and has served in that capacity since 2003. Prior to that, she was a manager in the Long Term Care program, serving as Acting Director from 2000-2003; and served in several capacities with Kalamazoo Community Mental Health Services, including Chief Operating Officer and Deputy Director of Systems and Operations, Co-Acting Director, Director of Family Services, and Children's Services Coordinator.
/2012/The Division currently has 60 established positions including 13 vacancies. There are also 19 professional contractual staff.//2012//
/2013/ There are currently 45 filled positions in the Division, including 6 clerical positions. There are nine vacant positions at the present time.//2013//

The WIC Division administers the federal Supplemental Food Program for Women, Infants and Children and Project FRESH. The Division has 43 funded positions, including six vacancies. Staffing includes nutritionists, public health consultants, analysts and managers. Stan Bien is the Director of the WIC Division. Mr Bien has 25 years of management experience, including 22 years with the WIC Division. He has a Bachelor's of Science degree in Accounting and a Masters degree in Public Administration.
/2013/ The WIC Division currently has 36 filled positions, including 6 clerical positions. Of the ten current vacant positions, two are section manager positions.//2013//

The Children's Special Health Care Services Division currently includes 46 funded full time positions including one vacancy. Professional staff is made up of doctors, nurses, nutritionists, analysts and managers. Support staff perform clerical, technical and enrollment functions. Parents of children with special needs, working through the Family Center for Youth and Children with Special Health Care Needs perform an advisory role to the department as well as developing support networks across the state for parents of special needs children. The Family Center currently employs eight staff total, five of whom are parents of children with special needs.
/2013/ THe CSHCS Division currently has 36 filled positions and ten vacant positions.//2013//

Kathleen Stiffler is the Director of the Children's Special Health Care Services Division. Ms. Stiffler has over 24 years of experience in various capacities within the Maternal and Child Health area, including over seven years as the director of Michigan's Children and Youth with Special Health Care Needs Program. As the CYSHCN Director, Ms. Stiffler has overseen a significant effort along with the Division's many partners, to move the state closer to meeting the 2010 objectives for CYSHCN. This included a comprehensive strategic planning effort in 2008 that included over 100 partners. Progress has been made since that time on all six 2010 objectives. Additionally, Ms. Stiffler oversees the operations of the CSHCS program that provides insurance coverage and support services to over 30,000 children and youth with special health care needs. Before accepting the CYSHCN position, she served as the Unit Director for Adolescent Health for over eight years. In that capacity she was responsible for directing program and policy development, program implementation and monitoring, quality assurance, evaluation and program improvement for Michigan's adolescent health programs. The focus of adolescent health programming in Michigan includes school-based/school-linked teen health centers (primary care programs designed to address the unique needs/strengths of the adolescent-aged population) and teen pregnancy prevention. Prior to that, Ms. Stiffler was the Chief of the Prenatal and Infant Care Section. Ms. Stiffler holds a Master's Degree in Health Education and is currently on the Board of Directors for the Association of Maternal and Child Health Programs.
/2012/Effective May 16 2011, Richard Cummings became the Acting Director of the Children's

Special Health Care Services Division. Mr. Cummings has been with the Division for nineteen years, the last thirteen as Director of the Customer Support Section of the CSHCS Division responsible for reviewing and approving program eligibility applications, payment agreements, and client coverage changes. Prior to joining the Division he served in various financial management capacities with the Michigan Department of Public Health. He has a Bachelors Degree in Accounting. Mr. Cummings will serve as Acting Director of the Division until his retirement at the end of June. In the meantime, the process of permanently filling the Division Director's position is ongoing.//2012//
/2013/ Lonnie Barnett was appointed Director of the ChidIren's Special Health Care Services Division in August 2011. Mr. Barnett has 20 years of state and local experience in health assessment, health planning, primary care systems development, workforce development and the uses of data to inform and develop policy. He was employed as a community health planner for the Kent County Health Department in Grand Rapids, Michigan, and, previous to his appointment as CSHCS Division Director, was Manager of the Health Planning and Access to Care Section of the Michigan Department of Community Health. He has a Master of Public Health degree from the University of Michigan and completed undergraduate studies in Biology and Economics at Emory University.//2013//

The Office of Medical Affairs within the Medical Services Administration houses two full-time physician consultants dedicated specifically to CSHCS, and three physicians who dedicate a portion of their efforts toward CSHCS needs. Their role is determination of program eligibility, approval of CSHCS specialists, and approval of specific specialists to serve the CSHCS beneficiary.

The Bureau of Epidemiology, Division of Genomics, Perinatal Health and Chronic Disease Epidemiology includes a Maternal and Child Health Section with seven positions (three vacancies). This section works with staff of the Bureau of Family, Maternal and Child Health on data collection, analysis and evaluation. The Newborn Screening Unit has six professional staff. This unit follows up on newborn screening tests and results with hospitals, physicians and parents.

E. State Agency Coordination

The Michigan Department of Community Health includes the Medical Services Administration (responsible for the Medicaid and MIChild programs), Mental Health and Substance Abuse Administration, Public Health Administration, Services to the Aging, and Health Policy and Regulation Administration (responsible for licensing of health professionals and facilities). In administering the Medicaid and MIChild programs, DCH works closely with the Department of Human Services, the state agency responsible for eligibility determination for Medicaid and other assistance programs.

Directors of the Departments of Community Health, Education, Human Services, Corrections and Energy, Labor and Economic Growth meet on a regular basis to coordinate policy and discuss cross-cutting issues affecting our common clients. Most recently, each department has identified their top priorities that require interagency coordination of policy and activities. The Department of Community Health has identified infant mortality as our interagency priority; Human Services -- poverty; Corrections -- Michigan Prisoner Re-entry Initiative; Energy, Labor and Economic Growth -- No Worker Left Behind; and Education -- Education Reform.
/2012/At this point in the new Governor's administration, the Interagency Directors meetings have been put on hold while the new department directors get settled into their roles and the state's budget is being worked out.//2012//
/2013/ The Interagency Director's group has been replaced by the People Group, including the Departments of Community Health, Education, and Human Services.//2013//

In addition to the projects mentioned above, other interagency efforts include projects addressing healthcare workforce issues (Interagency Healthcare Workforce Coordinating Council, Michigan Opportunity Partnerships, Governor's Accelerated Health Career Training Initiative), Autism Spectrum Disorder Workgroup, and Foster Youth Development Program. The workforce initiatives will address current and predicted critical health care worker shortages in the state, particularly nurses and physicians, by expanding educational opportunities and re-training workers and by offering online information to healthcare employers and career seekers. The Autism Spectrum Disorder Workgroup developed recommendations to the Directors in regard to early identification, appropriate treatment and education. Two pilot sites to implement the recommendations on screening, assessment and evidence-based practice interventions and evaluation of results began in October 2008. The Foster Youth Development Program helps youth transitioning out of foster care to achieve independent living status by assisting them with education and employment goals, housing, and learning how to access and use the health care system.

DCH and the Department of Human Services continue to work together on outreach activities to low-income families eligible for public programs. The Department of Human Services (DHS) provides information and helps families apply for Medicaid and MIChild, determines Medicaid eligiblity and updates relevant information for Medicaid beneficiaries. DCH and DHS collaborate on policies and processes for making low income families aware of their eligibility for public assistance programs through various state and local sources, particularly families leaving the TANF program due to increased income or noncompliance with work requirements. DCH and DHS also collaborate on family preservation efforts, the Safe Delivery program targeting new mothers who may want to surrender their babies, and the Child Death Review Program. Both departments maintain representation on the State Child Death Review Team.
/2013/The Department is working with the Children's Trust Fund to include the ACE (Adverse Childhood Experiences) module in Michigan's 2013 BRFSS. This module contains questions related to such topics as physical and emotional abuse, substance use in the home, sexual abuse, violence between adults in the home, and incarcerated member of the household that may lead to negative adult health outcomes.
In addition, DCH and DHS are working together to update public messages regarding Safe Sleep to focus on infant suffocation deaths.//2013//

DCH and the Department of Education collaborate on school health programs and work together on the Early On initiative (Part C of IDEA). The activities of the Early On program are directed by the State Interagency Coordinating Council and include technical assistance and training for local coordinating councils. Staff from the Division of Family and Community Health, the Division of Mental Health Services to Children and Families, and CSHCS participate on the state council. The departments also cooperate in administering the Youth Risk Behavior Survey and the School-based Health Centers and in the design and implementation of the Michigan Model health education curriculum. DCH works with the Department of Education to develop plans for assisting schools not meeting performance expectations under No Child Left Behind, and to support a "shared" public health consultant position to focus on the social/emotional health of school-age youth.

DCH joins with the Departments of Agriculture and Environmental Quality in developing and implementing the Michigan Local Public Health Accreditation Program. This program institutes a baseline standard for characteristics and services that define a local health department. The program includes a self-assessment and on-site review components and is operated on a three-year cycle. DCH contracts with the Michigan Public Health Institute to house, staff and coordinate the program. More information on this program can be found at www.accreditation.localhealth.net.

The Title V Director is the Department's liaison with the Michigan Women's Commission. The two agencies partner on issues affecting women in the state, such as infant mortality, unintended

pregnancy and domestic violence. The Title V Director also serves as a member of the Michigan Pandemic Influenza Coordinating Committee (PICC) and Chair of the Human Health Committee. The PICC coordinates pandemic flu activities vertically and horizontally across state agencies.

The Title V program participates in an ad hoc workgroup that has been convened within the Department to coordinate and share information on several medical home projects in the department, including Chronic Disease, Medicaid and CSHCS.

The Michigan Public Health Institute, a non-profit corporation, was authorized by Public Act 264 of 1989 as a cooperative venture of the Michigan Department of Public (now Community) Health, the University of Michigan, Michigan State University and Wayne State University to plan, promote and coordinate public health research, evaluations and demonstrations. The Institute's board of directors includes representatives from each of the universities and the department. Since its creation, the Institute has worked with the department on several important initiatives including: evaluation (e.g., Maternal Support Services, Michigan Abstinence Partnership, Local Public Health Accreditation Program); developing new programs and projects (e.g., Suicide Prevention, child death review teams); training and technical assistance activities (e.g., development of a standard tool for reporting death scene investigations of sudden and unexplained child deaths and training of local child death review team members); and data collection and reporting (e.g., child death review database, PRAMS).

With the statewide implementation of Medicaid managed care in 1998, EPSDT services were integrated into the qualified health plans (QHPs). Most local health departments no longer provide EPSDT services. The MCH program continues to work with the Medical Services Administration to develop standards of performance and quality for the plans and provides technical consultation. The MCH program also provides training for QHPs and local health departments on the hearing and vision components of EPSDT.

In 2008, the Department of Community Health convened the Michigan State Leadership Workshop to begin work with stakeholders to strengthen the infrastructure for and outcomes of the EPSDT program. The group identified sixteen topics of common concern: MI Care Improvement Registry (MCIR) augmentation; medical home QI project; ABCD to scale; CSHCN into managed care; community resources; improve linkages between medicine and public health; care coordination/case management; early childhood mental health; expand role of WIC; EPSDT coordinators in local health departments; telemedicine (CSHCN); fiscal analysis; care for parents; foster care; child health work group; and developmental services/Early On. For the short-term, six priority areas were identified: use data to help assure access and quality; using Medicaid managed care to serve CSHCN; assure appropriate information exchange across services and systems; implement and operationalize a common definition of the pediatric medical home; improve the Part C Early Intervention (Early On); and improve access to early childhood mental health services. Six workgroups were formed to explore actions and recommendations in each of these areas. Follow-up on priorities identified at the Michigan State Leadership Workshop is taking place through Michigan's Early Childhood Comprehensive Systems interdepartmental advisory body, the Great Start Systems Team. Medicaid has worked with the MI Care Improvement Registry (MCIR) to add fields to document delivery of EPSDT services. /2012/Due to budget cuts and staffing limitations, the Leadership Workshop was disbanded. However, activities to achieve the intent of the Workshop continue to be pursued through other means, e.g., MCIR augmentation, medical home project, CSHCN managed care.//2012//

The protection of the public's health under the Public Health Code is a partnership between the state and local health departments (LHDs). The state health department has responsibility for general supervision of the interests of the health and life of the people of Michigan, promoting an adequate system of community health services throughout the state, and developing and establishing arrangements and procedures for the effective coordination and integration of all public health services, including effective cooperation between public and non-public entities to provide a unified system of statewide health care. With the responsibility for many personal care

services including maternal and child health services shifted from local public health to qualified health plans, the role of local health departments has changed somewhat to emphasize assurance of community capacity to provide needed services and accountability for the health status of the community. LHDs continue to carry out the core functions and to provide services aimed at communicable disease control, protection of food and water supply, casefinding and service coordination and planning for children with special health care needs, health education and public information. In addition, the LHDs provide a link to other social and public services. The state health department supports the local health system with funding, training, technical assistance and data resources.
/2013/ Due to a critical financial situation, the Mayor of the City of Detroit has proposed elimination of the city's health department. A proposal to turn over the responsibilities of the city health department to a public nonprofit agency, the Institute for Population Health, effective October 1 2012, has been advanced and is being considered by the City Council. Under the Public Health Code, Detroit is not required to operate a health department. Another option is for Wayne County to take over responsibility for public health activities within Detroit. The Department of Community Health is working with Detroit officials to assure that the citizens of Detroit will have access to essential public health services.//2013//

WIC is part of the Bureau of Family, Maternal and Child Health and continues to be an important component of strategies to improve the health of pregnant women, mothers and children. WIC clinics routinely make referrals for lead screening, Maternal and Infant Health Program, and prenatal smoking cessation. The clinics also routinely check immunization status and either refer or provide immunizations on site. Outreach activities are coordinated through the MCH hotline.

Availability and accessibility of family planning services is a key strategy for reducing unintended pregnancy and teen pregnancy. State and federal resources are combined to assure that women and men in need of family planning services have access to them through a provider of their choosing and through referral arrangements with prenatal care providers, WIC and substance abuse programs. In 2006, approval of a Section 1115 Family Planning Waiver expanded Medicaid-covered family planning services to women 19-44 years old with family incomes up to 185% of poverty. Family planning services are a required component of capitated funding for Medicaid enrollees in qualified health plans. The QHPs are also required to reimburse other publicly funded family planning clinics for family planning services provided to any QHP enrollee. The Division of Family and Community Health provides continuing education and training to Title X family planning clinics and managed care providers. The Family Planning program also works with the Breast and Cervical Cancer Control Program (BCCCP) to provide follow-up diagnosis and testing for women who had an abnormal Pap test from Family Planning services. This group of women is too young for the services of the traditional BCCC program.

There are currently six Healthy Start programs in Michigan - Kalamazoo, Flint, Detroit, Grand Rapids, Saginaw and Sault Sainte Marie. The department created a collaborative network of all programs to share their experiences, discuss issues of mutual concern and interest, and to develop standardized evaluation criteria for the programs. The network meets approximately four times a year. The department also assists proposed new programs with their applications by providing data and technical assistance and supports an extensive program evaluation project involving four of the projects (Detroit, Grand Rapids, Sault Sainte Marie and Flint).

The implementation of Medicaid managed care has significantly changed the role of local health departments and the MCH program in assuring access to prenatal care. Qualified health plans are held accountable by contract for providing prenatal services in accordance with standards set by the Medicaid program. A separate organization is contracted to conduct enrollment activities. The Medical Services Administration is responsible for administering the managed care contracts, establishing performance standards, monitoring and evaluating performance. MSA contracts with the Health Services Advisory Group, Inc. to conduct annual performance reviews of all plans.

Many local health departments (LHDs) and community agencies continue to provide enrollment and outreach services to low-income women either through agreement with the QHP(s) in their area or with their own resources. Several have had to limit their activity due to funding constraints by reducing staff dedicated solely to enrollment and outreach or by concentrating on the non-Medicaid eligible low-income population. Local health departments are encouraged to partner with community agencies to extend the scope of their efforts.

The Parent Leadership in State Government project identifies, trains and supports parent leaders from among families who utilize specialized public services provided through DCH, Education, Human Services and/or their local counterparts, with a focus on providing consumer voice and input on local, state and federal program planning and policy development that impacts children and families.

F. Health Systems Capacity Indicators

#02 Health Systems Capacity Indicator
The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.
#03 Health systems Capacity Indicator
The percent of State Children's Health Insurance Program (SCHHIP) enrollees whose age is less than one year who received at least one periodic screen.

According to the 2011 data, there were more infants under one year of age on Medicaid than in 2010. The rate decreased slightly from 82.5 to 81.3 for infants who received at least one periodic visit. The number of infants on Medicaid continues to increase. Additional access to pediatric health care providers and additional providers are needed to facilitate the desired screenings and health care. The pediatric medical home needs to be expanded.
The numbers remain low for SCHIP infants and the rate remains within the range of 69.4 -- 77.2 that has existed since 2007. At 72.1 it is less than last years 77.2.
MDCH and partners are implementing the Primary Care Developmental Screening project (PCDS) with funding from the Early Childhood Investment Corporation/W.K. Kellogg, Medicaid, and Early On (Part C). The project will continue to April 2013. The Developmental Screening workgroup of the Great Start System Team continues to meet to review and recommend next steps around improving developmental screening. This includes establishing the means to collect and monitor data about screening, beyond that available from Medicaid based on billing. The MIECHV program continues to build system infrastructure, including establishing benchmarks and indicators for measuring home visiting success; these indicators include developmental screening and assessment.
Michigan's 120 Maternal Infant Health Programs (MIHP) serve pregnant and postpartum women and infant(s) insured by Medicaid. The risk identifier is evidenced based; care coordination interventions are standardized and home visitation is focused on both maternal and infant health outcomes. MIHPS are required to assess immunization and early periodic screening status of all enrolled infants and to assist with referral and transportation if an infant is not up to date. Documentation regarding whether an infant MIHP beneficiary has received at least one periodic screening is available on the infant discharge summary which is now electronic and stored in the state of Michigan's Single Sign On (SSO)data base. In the future, reports will be able to be run that capture the screening status of individual beneficiaries, as well as regional EPSDT status. Once the reports are available state MIHP staff will be able to analyze trends and prioritize MIHP programming and policy adaptations to assist.

#4 -- The percent of women (15 -- 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent of the Kotelchuck Index.
#5A -- Percent of low birth weight (<2,500 gms)
#5B -- Infant deaths per 1,000 live births
#5C -- Percent of infants born to pregnant women receiving prenatal care beginning in the first

trimester
#5D -- Percent of pregnant women with adequate prenatal care (observed to expected prenatal visit is greater than or equal to 80% [Kotelchuck Index]

Infant mortality is a complex issue. MDCH uses a lifecourse framework, Perinatal Periods of Risk, with consideration of the social determinants of health and a focus on disparity elimination, for developing strategies to improve pregnancy outcomes in relation to low birth weight, premature birth and access to and adequacy of prenatal care.

Michigan's infant mortality rate has not changed significantly in the last decade, and it remains higher than the national rate. Most infant deaths occur in the neonatal period. The infant mortality rate among Black and American Indian infants is more than twice the state rate, 3 times higher than White infants and 3.7 times higher than Asian infants. The leading cause of infant death is low birth weight [LBW]/prematurity followed by congenital anomalies. The Michigan infant mortality rate among low birth weight infants is 26 times higher than normal weight infants and has decreased significantly in the past decade. There has been no significant change in the LBW/prematurity death rate in the past ten years and the rate among black infants is more than twice the state rate and four times higher than white infants. The infant mortality rate is significantly higher among women who received inadequate prenatal care and decreased significantly among women who received intermediate or inadequate prenatal care. Disparities are highest among women receiving at least adequate prenatal care. About 50% of the births in Michigan are to mothers on Medicaid. Medicaid mothers have higher percentage of LBW infants, higher rate of infant deaths, less care in the first trimester and lower Kotelchuck Index scores. Recognizing that infant mortality is a public health problem, the governor has made infant mortality a priority strategy in the state of Michigan. An infant mortality Summit was held in October of 2011. Stakeholders gave input and priority strategies were identified: 1) improve preconception health, 2) improve reproductive planning and intended pregnancy, 3) promote home visitation services through the Maternal Infant Health Program, and the Nurse Family Partnership, 4) eliminate medically unnecessary deliveries prior to 39 weeks gestation, 5) prevention of preterm deliveries through cervical length screening and progesterone treatment 6) restoration of the regional perinatal system, 7) implementation of NICU follow up clinics, 8) breastfeeding promotion and 9) reduce the disparity in black/white birth outcomes. These strategies were selected because of the nature of their impact on the infant mortality problem. The department is working to implement the strategies with available resources. Currently there are limited funds allocated for the strategies

07B The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

February 1, 2012, the Healthy Kids Dental program was expanded to an additional four counties and is in 65 of 83 counties serving approximately 349,000 children. The Healthy Kids Dental program, which is the Medicaid dental benefit administered by Delta Dental Plan of Michigan, continues to provide access to oral health care for Medicaid enrollees by using their dental network. The utilization of dental services in these 65 counties continues to increase above 50 percent and is greater than the overall statewide utilization of 30 percent.
The SEAL! Michigan school-based dental sealant program was expanded from six to nine grantees due to a Delta Dental Foundation grant. The total number of schools being served increased from 90 to over 160 schools in FY12.
In FY11, 14,448 sealants were placed on 4597 children.

The SEAL! Michigan school-based dental sealant program expansion is critical since it represents one of the oral health evidence-based practices. In addition, there are a number of HP-2020 objectives around dental sealants. The Oral Health Program administers and provides oversight to the SEAL! Michigan program. The SEAL! Michigan grantees follow established protocols and are required to submit data on the services rendered. Dental sealants are a performance measure and a goal developed by the CMS Medicaid program for Medicaid utilization. In addition,

school-based dental sealant programs present a proven prevention program and increasing oral health preventive services is a priority.
The evaluation of the SEAL! Michigan program grantees is ongoing. The evaluation measure requires that the grantees demonstrate a 90% retention rate or better on dental sealant placements. For the overall program evaluation, the growth in the number of schools and children receiving dental sealants is important. For federal agencies and other organizations that monitor dental utilization, dental sealants are a major component for evaluation and program effectiveness. The school-based sealant programs expansion supports the ability for the State of Michigan to reach the HP-2020 objective for dental sealants.
The program and/or policy changes required to increase the number of children with dental sealants requires a commitment by the MDCH to implement a statewide school-based dental sealant program. The commitment requires dedicated funding so that the grantees can be sustained. A Program change will be to brand the SEAL! Michigan logo and contract with local agencies that the Oral Health does not fund. This will allow those local programs to be affiliated with the State program and the State will be able to collect data and show progress towards the HP-2020 sealant objective.

08: Percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN program
All children eligible for SSI are also eligible for Medicaid in Michigan. Therefore rehabilitation services are typically provided under Title XIX, often in the school under Medicaid-Reimbursed School-Based Services. Michigan Medicaid has a very extensive benefit package, and the need for further coverage would be rare. CSHCS provides medical services as needed based upon the CSHCS qualifying diagnosis. Therefore, CSHCS would provide medically necessary services not covered under Title XIX for children enrolled in CSHCS.

09A: General MCH Data Capacity: The Ability of the State to Assure MCH Program Access to Policy and Program Relevant Information
Michigan has the benefit of an Executive Information System/Decision Support System and a data warehouse with multiple years of data from Medicaid, WIC, CSHCS, and Vital records, all on similar platforms. These data sets are uploaded weekly, monthly and annually. The warehouse provides the ability to link individuals between different data sets and thus track the impact of participation in MCH programs on a population basis.
State vital records (live births records, death certificates, linked infant mortality file either by using the birth or the death cohort, fetal deaths) remain the main source for monitoring pregnancy outcomes. Death and birth files for infants as well as infant birth and mothers death certificates are linked on an annual basis for epidemiologic study, including the Michigan Maternal Mortality Review. The Michigan Maternal Morbidity Database (MMMDB), consisting of linked data from the Michigan Inpatient Discharge file and resident birth records, is the basis for much for our analyses of maternal morbidity.

A major project to update the Medicaid enrollment and payment system was completed in 2009. The new system includes online provider services, real time claims adjudication and improved services to clients, as well as having improved the quality of the data for epidemiologic purposes. One MCH Epidemiologist currently has access to the Medicaid enrollment and claims data bases. Birth certificates can be linked to WIC data sets. Currently WIC staff are in the process of gaining access to the Michigan Medicaid claims data bases on the Warehouse so that they can link these data for WIC clients as well.
Birth certificates and newborn screening records are routinely linked by the NBS Epidemiologist. These data have also been linked, for children with sickle cell disease, to Medicaid claims and to a Health Assessment Status form collected in the Michigan Care Improvement Registry to better understand long term follow up for children with sickle cell disease and possible prevalence of sickle cell disease in older children and adults.

Over the past several years, Michigan has increased its capacity and gained access to the majority of the database resources identified in the MCH Block Grant. The most recent addition

was access to the Michigan Hospital Discharge database. The State of Michigan continues to utilize this database for analysis of maternal mortality and morbidity, perinatal mortality and other maternal and child health indicators.

PRAMS is Michigan's only source of data on unintended live births as well as information on other aspects of pregnancy and postpartum experiences. PRAMS has been used to monitor the health status of mothers and infants as well as of services sought and received, and in developing public health policy such as the family planning waiver request. PRAMS data have been linked to the MIDB in the past. This coming year, Michigan PRAMS will be oversampling women in three counties of interest to the Kellogg Foundation.

Michigan has had a birth defects registry since CSHCS program data is linked with the Michigan Birth Defects Registry (BDR) to study prevalent conditions at enrollment.

The SSDI grant partially supports a MCH epidemiologist position in the Bureau of Epidemiology. This position provides technical support to MCH programs in collecting and interpreting relevant data, as well as managing the PRAMS survey and linking data from the State's Vital Records with other databases, including PRAMS, WIC, Newborn Screening and Medicaid.

09B The Percent of Adolescents in Grands 9 throught 12 who Reported Using Tobacco Product within the Past Month.

Data from the YRBS and the YTS are used to guide policy and program efforts that discourage tobacco use among high school-aged adolescents. Data from the YRBS and YTS are also used for surveillance and evaluation of Michigan's Five-Year Strategic Plan for Tobacco Use Prevention and Reduction 2008-2013 which includes five goal areas: 1) identify and eliminate disparities in tobacco use; 2) eliminate exposure to secondhand smoke; 3) increase tobacco dependence treatment among adults and youth; 4) prevent youth tobacco-use initiation; and 5) sustain tobacco control infrastructure and funding. Based on data demonstrating the disparate impact of secondhand smoke (SHS) exposure to low income employees and children, the Smoke Free Air Law was passed in May 2010. A smoke-free housing initiative was launched between 2010 and 2012 to lessen the impact SHS exposure on young children living in public and affordable housing complexes. The program is actively involved in increasing smoke-free environment policies on high school campuses. The program also supports an increase in tobacco prices as this is the number one evidence-based policy that discourages and decreases youth tobacco use. Smoking among students has dropped statistically significantly since 1997, but has remained flat in the last several years. Data collected from the 2011 Michigan YTS (YRBS data not yet analyzed) indicate: 40% of Michigan students in grades 9-12 reported that they have tried smoking a cigarette, even if it was only one or two puffs; 16.5% of Michigan students are current smokers, in that they have smoked at least one cigarettes in the last 30 days; and 10.9% of the Michigan students reported smoking regularly, in that they smoke at least 2 cigarettes per day within the past 30 days. These data indicate a slight trend in decreased use of tobacco by under-aged smokers.

IV. Priorities, Performance and Program Activities

A. Background and Overview

For the 2011-2016 period, five of the previous priorities were retained (some wording changes):

Increase the proportion of intended pregnancies

Increase the proportion of CSHCN population that has access to a medical home and integrated care planning

Reduce obesity in children, including children with special health care needs, and women of child-bearing age.

Address environmental issues (asthma, lead poisoning and second-hand smoke) affecting children, youth and pregnant women.

Reduce African American and Native American infant mortality rates.

Little to no consistent progress on reducing infant mortality and its associated risk factors (low birth weight, preterm birth and unintended pregnancy) has been made over the last five years. In addition, there is still great disparity in infant mortality rates among racial and ethnic groups. Activities to address these indicators for the next five years will focus on pre- and inter-conception health, social determinants of health and health behaviors. See NPM #01, NPM #08, NPM #15, NPM #17, NPM #18, SPM #02, SPM #03, and SPM #04.

The Children's Special Health Care Services Division developed a 2010 Action Plan for Children with Special Health Care Needs which included, for each national performance measure, an identification of gaps in policies, analysis of quantity and quality of services, and prioritized recommendations for action. Implementation of the plan is ongoing, including several medical home pilot programs and transition planning for youth with special health care needs. See NPM #2-6.

Activities to improve the health status of children and youth will continue to include cooperation and coordination with other DCH programs (Chronic Disease, Injury Control, Mental Health and Substance Abuse, Medicaid), other state agencies (Education, Human Services, Corrections, and Energy, Labor and Economic Growth), and other stakeholders (Michigan Dental Association, Delta Dental of Michigan, Michigan State Medical Society, March of Dimes, Michigan State University, etc.). Three new priorities will focus on reducing rates of sexually transmitted diseases among youth, increasing access to early intervention services and developmental screening, and increasing access to dental care. See NPM #07, NPM #09, NPM #10, NPM #11, NPM #12, NPM #13, NPM #14, NPM #16, and SPM #05.

/2013/ Statewide summits focusing on two of the Governor's Dashboard measures -- obesity and infant mortality -- were held in 2011. From the infant mortality summit, seven strategies were recommended to reduce the overall infant mortality rate in Michigan and the disparity in infant mortality rates between racial and ethnic groups: 1) implement a statewide regional perinatal system; 2) promote adoption of "Hard Stop" policies to reduce medically unnecessary deliveries before 39 weeks gestation; 3) promote adoption of progesterone protocol for high risk women; 4) promote safer infant sleeping practices to prevent suffocation; 5) expand home visiting programs to support vulnerable women and infants; 6) support better health status of women and girls; and 7) reduce unintended pregnancies.

In September 2011 a statewide summit on obesity was held to engage stakeholders from across the state the development of actions to reduce the obesity rates among the population overall and children. From the summit recommendations, the Department developed the "4 X 4 Plan" with the following strategies and goals:

Maintain a healthy diet	***Body Mass Index***
Engage in regular exercise	***Blood Pressure***
Get and annual physical examination	***Cholesterol level***

Avoid all tobacco use and exposure ***Blood sugar/glucose level***

A. Develop multimedia public awareness campaign to encourage every resident to adopt health as a personal core value through promotion of the 4 X 4 Plan
B. Deploy 46 community coalitions throughout Michigan to support implementation of the 4 X 4 Plan
C. Engage partners throughout Michigan to help coalitions implement the 4 X 4 Plan: employers, trade and other professional organizations; education system; and departments of state government.
D. Within MDCH, create the infrastructure to support 4 X 4 Plan implementation energizing the local coalitions and partners.
Within these strategies, the MCH program will promote breastfeeding as a means of reducing childhood obesity and the 4 X 4 Plan among women of childbearing age.//2013//

B. State Priorities

Increase the proportion of intended pregnancies
According to the Pregnancy Risk Assessment Monitoring Systems (PRAMS), less than half of the pregnancies in Michigan are intended. Intendedness of pregnancy has consequences for maternal health and pregnancy outcomes, as well as economic consequences. Services to support activities related to this priority include family planning (Title X and Medicaid) and Teen Pregnancy Prevention Initiative. Related Performance Measures are NPM #08 and SPM #01.

Increase the proportion of CSHCN population that has access to a medical home and integrated care planning
Children with special health care needs have complex medical problems that require care and services from multiple providers who are frequently not located in close proximity. Often, there is a lack of communication between providers and no focal point for coordination of care. Lack of coordination may cause the condition of already medically fragile children to deteriorate or fail to improve. Several projects are underway to develop or pilot medical home models, including the Department of Pediatrics Henry Ford Health System Cooperative Project, MCAAP Residents Training, and the CSHCS State Implementation Grant. Related Performance Measure is NPM #03.

Reduce obesity in children and women of child-bearing age, including children with special health care needs.
Data for Michigan residents indicate that rates of obesity for children and adults are increasing. Programs to address this issue include nutrition education through Child and Adolescent Health Centers, Michigan Model, WIC and the Michigan Nutrition Network. The Michigan Steps Up and Generation with Promise programs, developed and operated by Michigan's Surgeon General, promotes healthy eating and physical activity in school-age children and the general population. The Department of Community Health and the Title V program are also partners in the Healthy Kids, Healthy Michigan initiative with the Michigan Chapter of the American Heart Association and approximately 100 other organizations to plan and implement activities designed to reduce and prevent childhood obesity. Related Performance Measure is NPM #14.

Address environmental issues (asthma, lead and second-hand smoke) affecting children, youth and pregnant women.
Lead poisoning is a continuing priority in Michigan, with Black children disproportionately affected. Asthma is one of the leading causes of preventable hospitalization for children. 15.9% of mothers statewide and 31.2% of Native American mothers were exposed to second-hand smoke at home. Programs to address these environmental issues include the Childhood Lead Poisoning Prevention Program, Child and Adolescent Health Centers, Michigan Model, and the Prenatal Smoking Cessation program. Other programs outside of the Title V program address asthma through the Asthma Coalitions in Detroit, West Michigan, Genesee and Saginaw and MDCH

Healthy Homes University Program. Related Performance Measures are NPM #15 and SPM #05.

Reduce African American and American Indian infant mortality rates.
According to Michigan Vital Records, Black infants died at 2.7 times the rate for white infants and Native American infants died at 1.5 times the rate for white infants. Black infants were more than twice as likely to have low birth weight as white infants and have higher preterm birth rates. Services to address issues impacting infant mortality include Medicaid-covered services (prenatal care, delivery, neonatal care), Medicaid Outreach, Maternal and Infant Health Program, Safe Delivery, Safe Sleep, FIMR and Maternal Mortality Surveillance. Related Performance Measures are NPM #01, NPM #08, NPM #15, NPM #17, NPM #18, SPM #01, SPM #02, SPM #03, SPM #04 and SPM #10.

Decrease the rate of sexually transmitted diseases among youth 15-24 years of age
Chlamydia rates for 15-19 year-olds increased by 110.6% from 2000 to 2008, and gonorrhea rates increased by 38.5% for the same age group and time period. In addition to the services administered by the Bureau of Epidemiology Communicable Disease Section, Family Planning, Child and Adolescent Health Centers and Teen Pregnancy Prevention Initiative offer services to address sexually transmitted diseases. Related Performance Measure is SPM #06.

Reduce intimate partner and sexual violence
One of the factors affecting maternal depression is exposure to intimate partner and sexual violence. According to the Youth Risk Behavior Survey (YRBS), 12.4 % of high school students experienced dating violence in 2007, and 10.3% were forced to have sexual intercourse they did not want. The incidence of violence is significantly higher among Native Americans. Title V services to address this priority are included in the Maternal and Infant Health Program and the Child and Adolescent Health Centers. Related Performance Measure is SPM #08.

Increase access to early intervention services and developmental screening within the context of a medical home for children
Early identification and treatment of health and development problems in young children can prevent or mitigate the lifelong affects and improve the child's chance of success upon entering school. Programs to address this priority include CSHCS multi-disciplinary clinics, regional perinatal system, Early On, Great Start Collaborative (Early Childhood Comprehensive System), and the ABCD Project. Related Performance Measures are NPM #01, NPM #03, NPM #04, NPM #05, NPM #12, NPM #17 and SPM #09.

Increase access to dental care for pregnant women and children, including children with special health care needs
Oral health can affect other diseases/conditions and may place pregnant women at risk for pre-term births and low birth weight. In addition, other diseases, such as diabetes, can affect an individual's oral health. According to our Medicaid database, less than 50% of children 6 through 9 years of age received any dental service during 2008. Children with special health care needs especially have difficulty finding a provider. Thirty-nine of Michigan's 83 counties are designated dental Health Professional Shortage Areas. Related Performance Measure is NPM #09.

Reduce discrimination in health care services in publicly-funded programs.
All of the data indicators that were reviewed as part of the needs assessment demonstrated disparity between rates for the white population and other racial/ethnic groups. The Community Conversations series, hosted by the Health Disparities and Minority Health Section of the Public Health Administration, noted a distrust of health care professionals among minority communities and issues of cultural sensitivity and language barriers. A concerted effort to address these disparities must be made if we are to achieve improvements in health status indicators for the maternal and child health population. Related Performance Measures are NPM #08, NPM #11, NPM #13, NPM #15, NPM #18, SPM #01, SPM #02, SPM #03, SPM #04, SPM #05, SPM #06, SPM #07, SPM #08, SPM #10.

While the MCH program has lost significant state funding over the past two years for programs targeting infant mortality and pregnancy prevention, support is still provided to local programs in the form of data and consultation. In addition, the MCH program works with other MDCH programs and other state agencies to coordinate efforts aimed at our mutual target populations. Wherever possible, other funding sources are identified to maintain some level of service in these programs. For example, state funding support for five Nurse Family Partnership projects was eliminated in the FY 2009 budget. However, some of the local sponsors have been able to retain the Medicaid match with local funding sources. In addition, the Patient Protection and Affordable Care Act will enable us to restore and expand programs that address several of our priorities for the next five years.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	96.4	100.0	100.0	100.0
Numerator	203	190	220	277	200
Denominator	203	197	220	277	200
Data Source		NBS Program data	NBS Program data	NBS Program data	NBS Program Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

During 2011, 112,488 newborns were screened and 200 were diagnosed with one of 51 disorders. Communication with hospital-based NBS coordinators continued including provision of quarterly quality improvement reports based on hospital performance measures of number of unsatisfactory, late early and batched specimens and number of cards recorded on the electronic birth certificate. A new performance measure was included relating to number of bio-trust forms received with the consent for research section correctly filled out. Four contractual agreements were maintained for medical management on metabolic disorders, endocrine disorders, cystic fibrosis and hemoglobinopathies. A new agreement for the medical management of Severe Combined Immunodeficiency (SCID) was developed with The Children's Hospital of Michigan. SCID screening began October1, 2011 and as of May 2012, 9 cases of secondary T cell related immunodeficiency were detected. There were no cases of SCID detected. A preliminary proposal to add pulse oximetry screening for Critical Congenital Heart Defects to the newborn screening panel was presented to the Department's Newborn Screening Quality Assurance Committee.

The committee recommended that the newborn screening program conduct a pilot project to determine the efficacy of CCHD screening in Michigan
An attachment is included in this section. IVC_NPM01_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improve birthing hospital performance relative to proper NBS specimen collection and submission		X		
2. Maintain or increase the rate of screening and verify the number of newborns screened through linkage with vital records			X	
3. Improve screening performance for specific disorders as needed by examining metrics and recommending algorithm changes			X	
4. Increase the number of infants who receive appropriate short and long-term follow-up for a positive newborn screening test			X	
5. Obtain baseline data and develop strategies to reduce the proportion of children diagnosed with a disorder through newborn blood spot screening who experience developmental delay requiring special education services		X		X
6. Obtain baseline data and develop strategies to improve the care for children diagnosed with hemoglobinopathies through newborn blood spot screening		X		X
7.				
8.				
9.				
10.				

b. Current Activities
Michigan NBS staff continues to participate in the CDC hemoglobinopathies surveillance project (RUSH), Region 4 Genetics Collaborative and other initiatives related to NBS data sharing and quality improvement. The NBS program received the following grants to begin implementation in 2012: 1. A two-year CDC grant to assist in monitoring the impact of transfusion related complications on the health of the sickle cell disease population at four Michigan medical centers. 2. A three-year HRSA grant to implement pulse oximetry screening for CCHD.

c. Plan for the Coming Year
1.Develop a comprehensive strategy for implementation of CCHD screening including design of a complete ascertainment study protocol for determination of the sensitivity, specificity and detection rate of CCHD screening by pulse oximetry for 30,000- 35,000 consecutive Michigan births.
2.Implement PerkinElmer E-Reports for direct data entry of NBS demographic data by hospital personnel. This would make NBS data entry more efficient at hospitals and allow data entry by hospitals for point-of-care screening for hearing and CCHD. In addition, this process allows for the use of the current specimen gate/patient care modules for follow up of these non-blood spot screens.
3.Work with four Michigan medical centers and the CDC to begin monitoring the health impact of transfusions on the Michigan sickle cell population.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**112974**					
Reporting Year:	**2011**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	112488	99.6	14	9	2	22.2
Congenital Hypothyroidism (Classical)	112488	99.6	1030	78	78	100.0
Galactosemia (Classical)	112488	99.6	3	0	0	
Sickle Cell Disease	112488	99.6	73	52	52	100.0
Biotinidase Deficiency	112488	99.6	167	9	9	100.0
Cystic Fibrosis	112488	99.6	397	13	13	100.0
Other Amino Acid Disorders	112488	99.6	32	3	3	100.0
Other Fatty Acid Oxidation Disorders	112488	99.6	79	14	14	100.0
Organic Acid Disorders	112488	99.6	28	5	5	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	112488	99.6	125	8	8	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	112488	99.6	12	9	9	100.0
Severe Combined Immunodeficiency (SCID)	112488	99.6	79	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**

Annual Performance Objective	61.3	56.4	56.4	56.4	56.4
Annual Indicator	56.4	56.4	56.4	56.4	74.5
Numerator					
Denominator					
Data Source		NS-CSHCN 2005/06	NS-CSHCN 2005/06	NS-CSHCN 2005/06	NS-CSHCN 2009/2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	74.5	74.5	74.5	74.5	74.5

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
The Family Center for Children and Youth with Special Health Care Needs (Family Center) is a section of the Children's Special Health Care Services division (CSHCS). The Family Center is an integral part of the division. The Family Center provides services to families statewide and serves as the collective voice for families around the state enrolled in CSHCS. The information the Family Center receives from families is used to provide consultation to Michigan Title V programs regarding policy and program development. All written materials intended for families created by CSHCS, as well as CSHCS policy and procedure, are reviewed by the Family Center for recommendations or revisions. The Family Center provides review of the federal MCH Block Grant application, as was provided in 2011.

An important service the Family Center provided to families is the toll-free Family Phone Line. The Family Phone Line is used by families who have children with all types of special health care

needs throughout the state of Michigan, whether they are enrolled in CSHCS or not, meeting the broader definition of special health care needs as outlined by the MCHB. The Family Phone Line is used to assist families in accessing providers, obtaining information on the CSHCS program, and general information and referral for families of children with special needs. In 2011 the phone lined handled 18,928 calls. In an effort to be culturally competent and accessible to all families, the Family Phone Line subscribes to a Language Line to increase access for individuals who do not speak English. In 2011 approximately 27 calls used the language line, primarily for translation into Spanish and Arabic. The Family Center also manages a newsletter for families of children with special health care needs. In 2011, 36,000 copies of the Heart to Heart newsletter were sent out to families and professionals working with families.

The Family Center continues to provide parent support through their Family Support Network of Michigan. The Family Support Network matches support parent volunteers with other parents in similar situations in need of support. In 2011 the Family Support Network made 103 parent matches and held 6 support parent trainings providing services across the state of Michigan for parents with children with special health care needs.

The Family Center also provides conference scholarships for youth and family to attend conferences around the United States that pertain to their diagnosis. In 2011 the Family Center provided most of those scholarships for families to attend the biennial Relatively Speaking conference organized by the Family Center. Thirty-Four family scholarships were awarded for the conference, uniquely geared towards parents and siblings of special needs children. 175 people attended the two day conference held in Grand Rapids, Michigan. 2011 marked the 13th anniversary of "Relatively Speaking", what is believed to be the countries only weekend conference dedicated to the issues of siblings of children with special health care needs.

In addition to providing funding for families, the Family Center was able to provide funding to local health departments in the form of mini-grants to support local health in their efforts in partnering with families. In 2011 mini grants were awarded to four local health departments, increasing family participation at the local level. With the funding the Family Center provided to our local health partners the following counties were able to accomplish family activities; Ottawa County hired a parent to attend meeting, event planning and a newsletter. Livingston county hired a parent to work on surveys getting input from how the services are in there county. Macomb County held an annual open house, a bi-annual newsletter. Midland County expanded their Parent Network. Calhoun County established a family advisory committee, and developed a local newsletter. Tuscola County conducted a focus group, conducted a needs assessment. Wayne County hired a family advocate, and started a family advisory group.

The Family Center also is Michigan's current HRSA grant holder as Michigan's Family to Family Health Information and Education Center. The Family Center has been providing services to families of children and youth with special health care needs under the Family to Family Center since 2005.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Family Center provided review of CSHCS materials and policy, including review of the Title V Block Grant.				X
2. Handled 18,928 calls through the Family Phone Line.		X		
3. Matched 103 parents through the Family Support Network of Michigan.		X		
4. Held 6 trainings for support parents through the Family Support Network of Michigan.		X		
5. Organized the biennial Relatively Speaking conference, a conference for families and siblings of children with special		X		

health care needs.				
6. Provided 34 scholarships for families to attend the Relatively Speaking conference.		X		
7. Provided mini grants to 8 local public health departments to use for family partnership activities.		X		
8. Trained families and professionals through Family to Family Health Information Center trainings.		X		
9. Provided training and outreach to 13 community organizations.				X
10.				

b. Current Activities
The Family Center is currently involved in the appeals process for CSHCS enrolled families who are appealing decisions made by the division. Family Center staff is the first line contact for families in this situation. Family Center staff are able to research the unique situations and decisions and often times can provide resolution for the family without taking the matter through the lengthy administrative appeals process. Families going through the appeals process have expressed appreciation of the ability to work directly with a parent of a special needs child.

The CSHCS division is currently awarded with two HRSA funded grant projects; Innovative Strategies in Services to Children and Youth with Epilepsy and Integrated Community Systems for CSHCN. The Family Center is working closely with these projects to provide parent leadership support and training. Family Center staff provides coordination of all parent leadership activities pertaining to the grant projects.

c. Plan for the Coming Year
The Family Center will continue to provide consultation to the Michigan Title V programs, as well as keeping existing services to families that include:
•The Family Phone Line
•The statewide Family Support Network
•Conference scholarships for parents and young adults to learn more about diagnosis, care and advocacy.
•In service training for families, Pediatric Regional Centers, Medicaid HMO's, Local Health Departments, and other agencies
•Trainings to parents and professionals through the Family to Family Health Information Resource Center.
•Continue to provide mini-grants for local health departments to increase family involvement at the local level.
•Provide outreach and education to organization, schools, clubs, etc. about the CSHCS program and its benefits.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	55.8	46	46	46	46
Annual Indicator	46	46	46	46	43.7
Numerator					
Denominator					

Data Source		NS-CSHCN 2005/06	NS-CSHCN 2005/06	NS-CSHCN 2005/06	NS-CSHCN 2009/2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	43.7	43.7	43.7	43.7	43.7

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
2011 saw the end of the three year HRSA-funded, Michigan's Integrated Community Systems of Care for Children and Youth with Special Health Care Needs project. The projects aim was designed to support the implementation of the six core components of a system of services for children and youth with special health care needs (CYSHCN). Implementation was being supported through the establishment and regionalization of the medical home model throughout the State of Michigan. Over the three years of the project, 14 practices around the state were recruited to participate as Family Centered Medical Homes. The practices were located in urban and rural areas; they were large and small, public and private. Diverse practices were chosen in order to have a range of practice-based experience to guide the development and evolution of pediatric family-centered medical homes in Michigan.

At the end of the project an evaluation was conducted. The Medical Home Index (MHI) was used as a tool for practices to assess their own areas of strength and needed improvement. From Time 1 to Time 2 ratings, 10 of 12 practices (83%) showed an increase in the overall LEVEL of MHI rating across all categories.
Personnel from 13 practices participated in structured interviews at both the beginning and end of

their participation in the demonstration project. Ten practices felt they had a strong likelihood of sustaining the medical home activities initiated through this demonstration project. Ten practices felt their project activities had a substantial, positive impact for patients with special health care needs and their families. Eight practices noted that participation in the demonstration project had a positive impact on the practice itself.
To continue the spread and sustain the medical home model piloted, the division was awarded a new HRSA-funded Integrated Systems for CSHCN grant. The new grant project, Michigan's FQHC Medical Home Model for Children and Youth with Special Health Care Needs, aims to spread the family-centered medical home model to a Federally Qualified Health Center (FQHC) in rural Michigan. The project began September of 2011. A project coordinator was hired and staff is working with the Alcona Health Center, a large FQHC system serving three Michigan counties.
In 2011 progress continued on the HRSA grant "Innovative Strategies in Services to Children and Youth with Epilepsy". The purpose of the project is to assure that the best quality of health care services is available to children and youth with epilepsy in designated rural and medically underserved areas of Michigan with the use of telemedicine.
Accomplishments:
1.Two pediatric telemedicine sites are running monthly pediatric epilepsy clinics. Dickinson Pediatric Clinic, Iron Mountain, Michigan connects with Helen De Vos Children's Hospital. Alcona Health Center connects with the University of Michigan Pediatric Neurology Department.
2.A total of 19 patient clinic appointments have been held between October 1, 2011 and April 30, 2012.
3.Patient/family satisfaction is 100% rating the telemedicine clinics.
4.The originating site, the site where the patient and family are located, is the Pediatric Medical Home for each child/youth with epilepsy.
5.Care Coordination is provided within the medical home setting.
6.Provider satisfaction, at both the primary care physician and the pediatric sub-specialty sites, are rated at 95%.
7.Equipment has been placed at two additional sites. These sites will be operational within the next few months.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Partnered with 14 primary care practices for the Integrated Services Medical Home Implementation grant (D70)		X		X
2. Completed and evaluated work on Michigan's Integrated Services Medical Home Implementation grant (D70)		X		X
3. The division was awarded and began work on a new Integrated Services grant project, Michigan's FQHC Medical Home model.		X		X
4. Partnered with large FQHC in rural Michigan, Alcona Health Center, to implement and spread the medical home model.		X		X
5. Established 2 pediatric telemedicine sites running monthly pediatric epilepsy clinics.	X	X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Michigan's FQHC Medical Home Model for Children and Youth with Special Health Care Needs and Innovative Strategies in Services to Children and Youth with Epilepsy grant projects are

currently coordinating activities within the Alcona Health Center FQHC. The Alcona Health Center is the main focus for expansion of the Medical Home Model; they are also a pilot practice for telemedicine for children with epilepsy. Both projects have partnered with the Family Center to coordinate family advisory activities within the medical home.
The project, Michigan Primary Care Transformation (MiPCT) demonstration is a state-wide demonstration project to implement medical concepts into practices across the State. The demonstration focuses on the advanced primary care practice (patient-centered medical home) model; a team approach to care with the patient at the center that emphasizes prevention and uses health information technology, care coordination and shared decision-making between patients and their providers to improve chronic illness and preventive care. The project has a steering committee for implementation, included on that steering committee is Jane Turner, MD, the CSHCS Medical Home Physician Champion. This association will provide not only the critical input of a pediatrician into the demonstration project, but a pediatrician who can provide a voice at the table for CYSHCN.

c. Plan for the Coming Year
Innovative Strategies in Services to Children and Youth with Epilepsy will expand the use of telemedicine at medical home primary care practices. The project currently has two pilot practices providing telemedicine services. In the coming year the project will add XX practices that are actively utilizing telemedicine to connect children and families
One of the identified priority areas of the 2011-2016 Title V Needs Assessment is ensuring CYSHCN have a medical home. "In order to more effectively address the complex needs of CYSHCN, the establishment of a medical home is critical to the coordination of primary and specialty services. Efforts will continue to define and implement the medical home concept for CYSHCN in Michigan. Early intervention and developmental screening services will allow children to develop to their full potential and enhance their learning ability." Children's Special Health Care Services will be working closely with our partners in public health and Medicaid to ensure that the large scale patient centered medical home projects taking place across state include children and youth with special health care needs and their families.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	66.5	60.8	60.8	60.8	60.8
Annual Indicator	60.8	60.8	60.8	60.8	59.9
Numerator					
Denominator					
Data Source		NS-CSHCN 2005/06	NS-CSHCN 2005/06	NS-CSHCN 2005/06	NS-CSHCN 2009/2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than					

5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	59.9	59.9	59.9	59.9	59.9

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
Children's Special Health Care Services (CSHCS) provides coverage for medical care and treatment for 2,500 different diagnoses. In 2011 the program provided services to 36,065 children and some adults. Children's Special Health Care Services also has the Insurance Premium Payment Benefit. This benefit has been in place for over 16 years, whereby the state pays the private health insurance premium for the eligible client. This benefit allows for the CSHCS client to maintain their private health insurance coverage that they may otherwise not be able to afford. This enables the state to prevent a shift in the cost of medical services from the private health insurance company to CSHCS state funding. The majority of the premiums paid by the benefit are when COBRA coverage is offered to a family when the policyholder loses a job or a young adult is no longer a dependent. Cost effectiveness must be proven in order for CSHCS to pay premiums. In 2011, the Insurance Premium Payment Benefit assisted 260 families with insurance premiums, saving the program over 3.5 million dollars.

In 2011 CSHCS began discussions regarding the use of Michigan's High Risk Pool (HIP Michigan), created based on Health Care Reform guidelines. Discussions centered on the possibility of paying HIP Michigan insurance premiums for the 18 and over population enrolled in CSHCS with no other insurance, in particular the payment of insurance premiums for those with Cystic Fibrosis and Hemophilia. By paying the premiums for enrollment in HIP Michigan not only would CSHCS be saving state dollars by preventing medical costs being charged to state funds, but it would also provide a more comprehensive coverage for this population that would include primary care. An analysis was done to determine the feasibility of implementing a policy requiring certain diagnosis populations within CSHCS to enroll in the HIP program. Based on the analysis a cost savings for the State would be achieved by enrolling the 18 and over population with Cystic Fibrosis and Hemophilia in the HIP program. The HIP Michigan leadership was open to the idea of working with CSHCS on the enrollment of this population into the program. In 2011, meetings and discussions were held on the development of the application and the enrollment process.

In 2011 a new CSHCS policy became effective, requiring applicants who, based on financial

information provided, may be eligible for MIChild (Michigan's SCHIP program) to apply for the program. The policy was put in place from a legislative mandate on the CSHCS program. Because CSHCS provides payment for medical care and treatment of approved diagnoses only, some clients may not have access to primary care services because of lack of coverage. If a client is enrolled in MIChild, the child would have increased access to primary care services. It will also offset costs for CSHCS associated with the medical care and treatment of the child.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implemented new CSHCS database for more efficient information sharing with local CSHSC offices.				X
2. Began participation in the Michigan Local Public Health Accreditation Program.				X
3. Partnere with local public health to create six minimum program requirements for local CSHSC offices through the Michigan Local Public Health Accreditation program.				X
4. Provided training and outreach to 13 community organizations.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Division has begun a voluntary application process for the population identified for required enrollment in the Michigan's high risk pool (HIP Michigan). Once a policy has been promulgated requiring this enrollment, the application process will be mandatory. The population identified as automatically cost effective for premium payment without an individual determination consists of the following: Age 18 and above who are covered by CSHCS for cystic fibrosis or four of the five hemophilia codes who do not have any other type of insurance including Medicaid or Medicare. There are just over 200 CSHCS clients statewide who fit these criteria. The state budget indicates an annual savings of $4 million just for this population.

The transition for the CSHCS population with Medicaid into Medicaid Health Plans (MHP) is currently underway and many workgroups have been formed to plan for and implement this change.

c. Plan for the Coming Year

The division will move forward with the mandated enrollment process for the identified over 18 population into Michigan's high risk pool. For CSHCS clients both under and over age 18 that are interested in applying for HIP Michigan, a cost analysis may be requested to determine if it would be a cost benefit to CSHCS to pay the premium. This is the standard process within the Insurance Premium Payment Benefit.

Work will continue to move the CSHCS/Medicaid dual eligible population into Medicaid Health Plans. A tentative date of October 2012 has been set for the implementation of the enrollment of this population. Workgroup meetings will continue to plan for and monitor this transition.

CSHCS will provide further program outreach to publicize the program to enroll new clients with

special health care needs. The Program will plan to systematically share information about the CSHCS program and its benefits at identified entry points in partnership with the Family Center for CYSHCN. CSHCS will also continue to partner with the Family Center for CYSHCN by reaching out to Children's hospitals, Pediatric Regional Centers, children's multidisciplinary clinics and client organizations such as the United Cerebral Palsy foundation, hemophilia foundation and others to provide training on accessing the program.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	75.7	90.9	90.9	90.9	90.9
Annual Indicator	90.9	90.9	90.9	90.9	71.7
Numerator					
Denominator					
Data Source		NS-CSHCN 2005/06	NS-CSHCN 2005/06	NS-CSHCN 2005/06	NS-CSHCN 2009/2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	71.7	71.7	71.7	71.7	71.7

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
Michigan relies heavily on our Local Health Department (LHD) partners to be the community based arm of the CSHCS program. CSHCS relies on the LHDs to assist families in locating additional resources within their community. Because CSHCS relies so heavily on the LHDs it is crucial that the division provides them with the most up to date information and streamlined process to handle client's needs. A new CSHCS database was implemented in March 2011. The database is now in use by all central office staff and our local health department partners and the technical issues that were experienced with the old system have been eliminated, making a more streamlined application, enrollment, and renewal process for all CSHCS clients and their families.

In 2011, the Division embarked on the process of participating in the Michigan Local Public Health Accreditation Program for local CSHCS offices. A CSHCS workgroup worked closely with our public health partners to craft minimum program requirements for local CSHCS programs. As a result of the Accreditation workgroups six minimum program requirements were developed for local CSHCS programs.

Minimum Program Requirement 1: The local health department (LHD) Children's Special Health Care Services (CSHCS) program shall assure that adequate, trained personnel are available to provide outreach, enrollment and support services for children and youth with special health care needs (CYSHCN) and their families.

Minimum Program Requirement 2: In accordance with the security and privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA), the local health department CSHCS program shall manage CSHCS client protected health information (PHI) in a secure and private manner that results in coordinated care.

Minimum Program Requirement 3: The local health department CSHCS program shall have family-centered policies, procedures and reporting in place.

Minimum Program Requirement 4: The local health department CSHCS program shall provide outreach, case-finding, program representation and referral services to CYSHCN/families in a family-centered manner and to community providers.

Minimum Program Requirement 5: The local health department CSHCS program shall assist families in the CSHCS application and renewal process as well as the application processes for other relevant programs.

Minimum Program Requirement 6: The local health department CSHCS program shall provide information and support services to CSHCS enrollees and their families.

The division also worked closely with the Family Center for CYSHCN to provide outreach and information to 13 organizations regarding the CSHCS program, its benefits, and how to access services including the pediatric medical home model.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided medical care and treatment to 36,065 CSHCS	X			

beneficiaries.				
2. Assisted 260 families maintain private health insurances by paying insurance premiums through the Insurance Premium Payment benefit.		X		
3. Partnered with Michigan's high risk pool, HIP Michigan, to plan for enrollment of CSHCS's over 21 population.		X		
4. Required CSHCS applicants who may be eligible for Medicaid of SCHIP to apply for coverage.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In March of 2012 an accreditation team from CSHCS began the first of the three year accreditation cycle site visits to local health departments. Six site reviews have been completed and ten more are scheduled to be completed by the end of the current calendar year.

A pilot project is currently being planned in partnership with Medicaid for a smart phone application available to CSHCS enrollees. The smart phone mobile application will be called "Blue Button" and will provide the responsible party of the CSHCS enrollee to access important information such as authorized provider's and local health department contact information on their mobile devise via a secure log-in. The pilot project intends to reach an estimated 1000 CSHCS enrollees for test. Those who utilize and download the Blue Button application during this pilot period will be asked to complete an in-application survey about their experience.

The CSHCS nurse consultant is working closely with local health departments to identify areas of need and to provide training and technical assistance in many areas. The work has greatly strengthened the partnership between CSHCS central office and the community based local health department staff. Currently the nurse consultant holds a monthly conference call with the local public health nurses. The teleconference provides a great opportunity to share information and provide training on issues identified at the local level.

c. Plan for the Coming Year

For the coming year the CSHCS program will continue to partner with the Family Center to provide further outreach to the community with trainings and information distribution to hospitals and medical providers. CSHCS will continue to work with our local health department partners in providing them with the most recent information about the program and providing technical assistance with the use of Nurse Consultants. The CSHCS Local Public Health Accreditation Program team will continue its schedule of site visits for the first three year cycle of the accreditation process. The team will work with local CSHCS offices to coordinate the review process.

The division is working with our IT vendor partner to create a public interface for our CSHCS database. The plan for the coming year is to implement a secure web-based public interface to our database that will allow families to complete and submit the CSHCS application on-line.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	5.8	40.8	40.8	40.8	40.8
Annual Indicator	40.8	40.8	40.8	40.8	41.2
Numerator					
Denominator					
Data Source		NS-CSHCN 2005/06	NS-CSHCN 2005/06	NS-CSHCN 2005/06	NS-CSHCN 2009/2010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	41.2	41.2	41.2	41.2	41.2

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments

The CSHCS division has worked to monitor closely the creation and distribution of transition anticipatory guidance letters. Each month in 2011 the Medicaid System, CHAMPS, identified clients based on their birthdates to create five client/family specific letters for ages 16, 17, 18, and 21. Additionally, monthly, any CSHCS authorized provider with a client turning 16, 18, and 21 received a letter reminding them of the importance to discuss transition planning with them at their next visit.

CSHCS has a strong history of working with parent partners to provide input and perspective into program planning and policy. In 2011, the division created an opportunity to contract with a youth consultant to provide young adult input and perspective into program planning and policy. The Youth Consultant has participated in division strategic planning, advisory meetings, and been trained on youth leadership skills. She also provides review and offers guidance to make division materials and outreach activities more youth friendly.

In 2011 the CSHCS Division partnered with the Michigan Family to Family Health Information and Education Center to create an online training module on the topic of health care transition through an agreement with Michigan Virtual University. The online training module includes a recorded presentation about health care transition and also incorporates video clips on the subject that were created by the Family to Family Health Information and Education Center. The course also includes links to online resources and transition planning documents to download. The course is on-line and has been added to the roster of available courses for special education professionals.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided transition anticipatory guidance to 7,000 transition age CSHCS enrollees.		X		
2. Hired a youth consultant.				X
3. Created an on-lline health care transition training module.		X	X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Our contract with the Youth Specialist continues and she is currently working to update the Family Center's Youth Scholarship program materials and a plan for communicating the scholarships availability to other young people on CSHCS. In addition to these activities the CSHCS Transition Specialist and the Youth Consultant collaborated on a workshop that was presented at the 2012 Association of Maternal Child Health Conference titled "Partnering with Youth to Shape Policy and Program Development".

c. Plan for the Coming Year

The CSHCS Division will continue to provide outreach and education to enrollees through the use of anticipatory guidance letters. With the movement of the dual eligible CSHCS and Medicaid population into Medicaid Health Plans and the changes that are taking place with the Affordable Care Act, the division will being reviewing and revising all transition anticipatory guidance that is sent to clients. Any changes and updates needed to the material will be made.

With the assistance of the CSHCS Youth Consultant, the Division will work to reinvigorate youth advisory activities. The Division will use social networking to connect with young adults and provide them with information and education about transition along with opportunities to get involved in policy and decision making at the state level.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	91	91	85	86	75
Annual Indicator	81.8	82.0	74.9	74.0	79.9
Numerator	154222	152195	139832	136556	144280
Denominator	188535	185604	186692	184536	180576
Data Source		Nat'l Imm. Survey, MCIR	National Immunization	National Immunization Survey	National Immunization Survey (NIS)
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	76	77	78	79	80

a. Last Year's Accomplishments
The coverage levels reported above include one dose of varicella (chickenpox) vaccine, (4:3:1:3:3:1). The most recent data available from the NIS is from quarter 3 of 2010 through quarter 2 of 2011. NIS no longer provides data for the measurement listed above for the 4:3:1:3:3 series. The 4:3:1:3:3:1 series completion rate for Michigan is 79.9% which is up from 74% recorded last year. Michigan continues to have one of the highest vaccination rates in the country for the administration of a birth dose of hepatitis B vaccine which is currently measured at 81.6%.

The most recent immunization rates for Michigan as measured from the National Immunization Survey (NIS) show Michigan at 75.0% for the 4:3:1:3:3:1:4 series of vaccines. 4:3:1:3:3:1:4 represents; 4 DTaP, 3 polio, 1 MMR, 3 hib, 3 hepatitis B, 1 varicella, and 4 pnuemococcal conjugate vaccines. This data is obtained from mid-year National Immunization Survey data compiled by the CDC. The period covered for this data is from quarter 3 of 2010 through quarter

2 of 2011. We show an increase from 68.7% last year to 75%. This is a significant increase in vaccine coverage for most routinely recommended vaccine showing a significant uptake in the newer vaccines added to the schedule.

From October 1, 2010 -- September 30, 2011 the Immunization Program ordered and distributed 2,518,878 doses of vaccine valued at $98,741,561.26 to local health departments and participating private providers.

In 2011 the Immunization Program successfully built a BMI module in the Michigan Care Improvement Registry (MCIR). The module was created to allow health care providers to enter height and weight information into the MCIR and that data would be utilized to provide clinical guidance including growth charts. Unfortunately the project has been stalled to a handful of pilot sites until Administrative Rules are fully implemented.

Michigan has continued to operate as a pilot by creating an electronic interface between our MCIR vaccine ordering and vaccine management modules with the vaccine management system (VTrckS) developed by CDC. The Immunization program has continued to pilot new functionality of the VTrckS and make modifications to the MCIR system to better interface with CDC. Michigan is one of 2 states to be involved with the electronic interface between the Immunization Registry and the VTrckS.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to enhance the Vaccine Inventory Module in the MCIR to better account for and track vaccine inventories in provider offices.			X	
2. Fully implement the electronic ordering of vaccines in the MCIR.			X	
3. Implement an electronic interface using HL7 messages in the MCIR to make reporting of immunization data to the MCIR more accurate, more timely, and more efficient.			X	
4. Continue to work with local health departments and other partners to track immunization levels statewide to identify pockets of need and identify areas with low immunization rates, and high exception rates.			X	
5. Monitor the vaccination levels and compliance rates for the newly introduced immunization requirements.			X	
6. Monitor the new Pneumococcal Conjugate 13 valent vaccine in all children less than 5 years of age in particular in children with high risk conditions.			X	
7. Work with local health departments and other partners to research barriers on the uptake of HPV vaccine in adolescents.			X	
8. Implement the school requirement for reporting of 7th grade students for the 2012/13 school year.			X	
9.				
10.				

b. Current Activities

The Immunization program is piloting the electronic data submission of immunization data from electronic medical records (EMR) to the MCIR. Much work has been done to modify the MCIR to accept this new data format and monitor data quality as it comes into the system. This new method for obtaining data will help the private provider to submit more accurate and timely data to

the MCIR. This method also supports single data entry into a clinics electronic medical record system for immediate upload to the MCIR. MCIR is working within the State's strategic plan of Health Information Exchange (HIE) of health data. To date, 5 pilot sites have been brought into production and are submitting data directly from the EMR to MCIR through the HIE gateway. This system also allows clinics to meet one of the requirements for Meaningful Use and therefore receive payments from Medicaid and Medicare.

The Immunization Program is working with local health departments to develop and distribute a best practice paper that local health departments can use to obtain better reimbursement for immunization administered to insured populations. The Immunization program is visiting all local health departments to learn the current capabilities of each of the LHDs.

c. Plan for the Coming Year

On Jan. 1, 2010 the new requirements became effective to be first reported by schools in Nov. 2010 which require a 2nd dose of varicella vaccine and age appropriate adolescents 1 dose of meningococcal vaccine and one dose of Tdap vaccine. Requirements were enforced for all new students who were at least 11 years of age or enrolled in 6th grade. The requirement is problematic since many 6th grade children are not old enough to receive Tdap or meningococcal vaccines due to age recommendations. Public Health Code and School Code amendments have been approved by the Legislative Affairs Division in the Governor's Office to begin the process to change to a 7th grade requirement. Better compliance could be accomplished by allowing providers to follow the nationally recommended schedule. The Immunization Program continues to work with the legislative liaison to move these legislative changes forward.

The Immunization Program is working to promote the use of Tdap vaccine among health care workers and OBGyn's.

The Immunization Program is partnering with the Michigan Hospital Association to promote vaccination of health care workers in hospital settings. The primary focus of this project is to promote Tdap and flu vaccines for all health care workers.

The Immunization program is working to enhance the interface between MCIR and the CDC VTrckS system to provide more complete and accurate data for the delivery of vaccine. This includes more accurate shipping hours for clinics for the delivery of vaccine, new method for collecting and monitoring of vaccine storage devices within the MCIR system, electronic renewal and enrollment of VFC providers using an interface built in the MCIR, and new functionality in the MCIR to better manage and account for all publically purchased vaccines.

The Immunization program will work toward full implementation of interoperability of electronic medical records and the MCIR, Work on this will be done in conjunction with the Michigan Health Information Technology Commission. Eventual progress will lead to a two-way interface with Electronic Medical Records.

Continued work to reach adolescent and providers caring for them to assure that all adolescents receive all routinely recommended vaccines. We will continue to monitor the uptake of newer vaccine recommendations for adolescents such as Meningoccocal and Tdap vaccines. Uptake for HPV vaccine continues to be slow for both males and females.

The Immunization Program created a flu vaccine pre-booking module in the MCIR that allows clinical staff to pre-book flu vaccine for the upcoming flu season. This module allows local health departments to monitor vaccine being pre-booked by providers within their jurisdictions for all publically purchased vaccines.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	17.4	17.4	17	16	15.9
Annual Indicator	14.0	16.8	15.5	14.4	12.5
Numerator	3127	3629	3354	2966	2562
Denominator	223398	216619	216619	205391	205391
Data Source		MI vital Records	MI vital Records	MI Vital Records	MI Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	12.4	12.2	12	11.5	11

a. Last Year's Accomplishments
The 4th Annual Moving Toward Solutions: Addressing Teen Pregnancy Prevention in Michigan conference was held August 18-19, 2011 in Traverse City, Michigan. Approximately 250 professionals (educators, social workers, counselors, nurses, faith-based leaders, etc.) were in attendance.

The nine (9) agencies (serving 14 counties) funded by the Michigan Abstinence Program (MAP) in 2009 were refunded for 6 months in 2011 when funding was restored for the Title V State Abstinence Education Grant Program (AEGP). The agencies began re-implementing abstinence-only education programs in their communities. Their first two-day coordinator meeting was held in June 2011. In 2011, grantees served 637 youth and 285 parents. AEGP funding is available through FY 2014.

A competitive RFP was issued in June 2011 for the Taking Pride in Prevention program, the newly formed Personal Responsibility Education Program (PREP). Funding was available for 10 agencies to provide evidence-based abstinence and contraception education programs in their communities. PREP funding is available through FY 2014.

The four (4) Teen Pregnancy Prevention Grantees, funded in 2009, continued to provide comprehensive teen pregnancy prevention programming to youth in their communities. In 2011, 2633 youth and 878 parents were served.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Provided abstinence education to 2250 youth.		X		
2. Provided parent education to 450 parents.		X		
3. Supported local coalitions and programs through the Teen Pregnancy Prevention Initiative.				X
4. Conducted a statewide media campaign.			X	
5. Provided comprehensive sex education to 900 youth.		X		
6. Provided parent education (regarding comprehensive sex education) to 450 parents.		X		
7. 4th Annual Moving Toward Solutions conference was attended by approximately 250 individuals.				X
8.				
9.				
10.				

b. Current Activities
The 5th Annual Moving Toward Solutions: Addressing Teen Pregnancy Prevention in Michigan Conference will be held August 12-14, 2012 in Grand Rapids, MI. Approximately 250 youth-serving professionals are expected to attend.

The Michigan Abstinence Program's nine funded agencies (serving 14 counties) continue to provide abstinence-only education programs to youth and parents in their communities. Their second two-day coordinator meeting will be held in June 2012. At least 2,250 youth and 450 parents are expected to be reached by MAP.

The Taking Pride in Prevention (TPIP) Program funded 10 agencies to provide evidence-based abstinence and contraception education programs in their communities. Grantees began programming in October 2011. Their first two-day TPIP Institute (coordinator meeting) was held in January 2012 and the second will be held in June 2012. At least 2050 youth and 980 parents are expected to be served. PREP funding is available through FY 2014.

MDCH is currently working on the development of two youth-focused pregnancy prevention PSAs. The PSAs were shot in May 2012 and will be finalized and distributed by August 2012.

c. Plan for the Coming Year
MDCH will continue to air the two newly created youth-focused pregnancy prevention PSAs.

MAP and TPIP grantees will continue to provide teen pregnancy prevention programming to youth and parents in their communities.

MDCH will host the 6th Annual Moving Toward Solutions Conference.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	25	30	35	40	26.5
Annual Indicator	23.4	31.3	26.0	26.4	27.0

Numerator	29350	41094	33579	34449	30242
Denominator	125417	131500	129152	130492	111985
Data Source		SEALS Data	SEALS Data	Kids County & MDCH Data Warehouse	MDOE
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	27	28	29	30	30

Notes - 2011
The data for 2011 is more accurate. The MI Dept of Education supplied the OHP with the actual number of 3rd graders. With the claims utilization data also being definitive from Medicaid, Healthy Kids Dental and MIChild, the number of unduplicated 3rd grade children is more accurate. Queries have been developed by agencies so they can now run the requests annually. With that information, the percentage has increased. Beyond 2014 when the ACA is implemented, it is hard to project the estimates.

Notes - 2009
A school-based dental sealant coordinator was recently hired to work with grantees on their data collection and reporting, as well as resolving discrepancies in the reports.

a. Last Year's Accomplishments
The Michigan Department of Community Health Oral Health Program (OHP) continued the state-wide dental sealant program in 2009-2010, targeting the first permanent molars for first and second grade students. Eligible schools were enrolled that have greater than 50% or more participation in free and reduced lunch programs. The SEAL! Michigan school-based dental sealant program continued with the base funding for the six programs. The small planning grant allowed another grantee to be added to the SEAL! Michigan program. A grant from the Delta Dental Foundation also allowed the OHP to contract with three more agencies bringing the total grantee agencies to nine for the fiscal year 2012. With the addition of these agencies, the number of schools went from 90 to over 160 schools. Data on the program continues to show improvement and over 14,500 sealants placed last year. School districts have contracted with the SEAL! Michigan grantees to return the following year to continue this service. The consent forms and information go out to parents at the beginning of the school year. Schools have helped promote the SEAL! Michigan program by placing announcements on school websites, and outdoor signs. Students received oral health education, fluoride varnish applications and referrals for emergent dental care. Data on the program included the number of children screened, the number of sealants placed and other socioeconomic and demographic factors, including race/ethnicity. The program uses the MDCH developed SEALS-like data system for data collection. The sealant coordinator monitors all grant recipient activities and provides technical and consulting services to the grantees and other local health agencies to support dental sealant placement. The coordinator hosts an annual day-long training program for the grantees. Brochures on a Q and A for school staff on selecting a school-based oral health care program was developed in consultation with the OHP, a SEAL! Michigan grantee agency and the Michigan Dental Association.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Oral Health Coalition				X
2. Oral Health Burden Document				X
3. Count Your Smiles Survey				X
4. State Oral Health Plan				X
5. Healthy Kids Dental expansion	X			
6. State-wide School-based Dental Sealant Program			X	
7. Community Water Fluoridation Equipment Grants			X	
8. Maternal Infant Health Program Infant Oral Health Pilot Project			X	
9. Babies Too! Infant Fluoride Varnish Program	X			
10.				

b. Current Activities

The Oral Health Program has implemented their own SEALS-like database to collect the data from programs, including race/ethnicity data. The sealant coordinator continues to look at different avenues to increase the SEAL! Michigan program. A workforce grant was submitted to a federal agency with the plan to implement the school-based dental sealant program using student dental hygienists. A dental hygiene program at a university agreed to partner with the OHP to address the needs in their community, which is a health professional shortage area. The SEAL! Michigan program has been accepted as a best practice model by the Association of State & Territorial Dental Directors (ASTDD). The annual training includes a module on infection control and continuous quality improvement plans on infection control have been implemented.

c. Plan for the Coming Year

Continue with the current number of grantees for the SEAL! Michigan program. Another grant application was submitted to the Delta Dental Foundation to help sustain and continue the three additional grantees that were awarded grants in the prior year. Additional funding was requested to award contracts with two more agencies was also included in the grant application. The SEALS-like data will be analyzed and a report with the data to be published in an issue brief. An evaluation plan to evaluate the SEAL! Michigan school-based sealant program will be developed. The brochures developed for school staff on the Q & A for selecting a school-based dental sealant program will be disseminated to schools, Dept. of Education staff and school-based health center programs. The annual trainings for grantees will continue.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	3.2	3	2.3	2.2	1.7
Annual Indicator	2.3	2.3	1.9	2.1	0.9
Numerator	47	44	36	40	17
Denominator	2019667	1945927	1945927	1909286	1909286
Data Source		MI Vital Records	MI Vital Records	MI Vital Records	MI Vital records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events					

over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	1.7	1.7	1.6	1.6	1.6

a. Last Year's Accomplishments
CPS Programming money was eliminated in FY11 so activities have been scaled back tremendously. MDCH assisted with maintaining the Child Passenger Safety (CPS) network by assisting with local CPS efforts and providing assistance to child safety seat programs of its 16 local Safe Kids coalitions as requested.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conducted CPS education on restraint use/installation.			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Assist local CPS efforts and providing assistance to child safety seat programs of its 16 local Safe Kids coalitions as requested.

c. Plan for the Coming Year
Assist local CPS efforts and providing assistance to child safety seat programs of its 16 local Safe Kids coalitions as requested.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual	40	20	20	20	18

Performance Objective					
Annual Indicator	15.8	15.3	18.5	17.8	18.4
Numerator	6619	6652	8302	5541	8539
Denominator	41890	43476	44879	31130	46409
Data Source		PNSS/PedNSS	PNSS/Ped/NSS	PNSS/PedNSS	PNSS/PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	19	20	25	25	25

a. Last Year's Accomplishments

Breastfeeding (BF) leadership in the Department continues to come from the WIC Division. We received targeted funding for breastfeeding peer counseling. This resulted in placing 63 WIC clinic-based peer counselors (PC) across the state. We provided 2 BF Basics trainings geared specifically for this new workforce. Additionally, we provided the PCs and the BF mentors/managers with a statewide training in September 2011. Good fortune allowed us to maintain our Breastfeeding Initiative (BFI) partnership with MSU Extension. This allowed us to continue providing BFI peer support via home visits, support groups and follow-up phone contacts.

Due to the positive feedback from the 2010 Every Ounce Counts breastfeeding campaign, WIC chose to rotate those same television and radio messages at key times during FY '11 -- '12. Once again, the Office of the Governor agreed to declare August as BF Awareness Month in Michigan with a formal Proclamation. The Division sponsored a walk to the Capitol to raise public and legislative awareness for the need to support breastfeeding mothers and babies. The Michigan BF Network and numerous community BF coalitions conducted similar walks. BF promotional displays were featured in four state office buildings and at local WIC agencies throughout the state.

Michigan WIC partnered with Genysis Health System (Flint) and St. Mary's Hospital (Grand Rapids) to provide lactation training for physicians, nurses, and WIC staff. The training titled, Building Bridges to Breastfeeding Duration focused on best practices -- including improved communication between health care providers to help mothers meet their breastfeeding goals. Breastfeeding took center stage at the the 2011 WIC Conference which featured National WIC Association Chair, Kiran Saluja as she spoke to the critical differences between the health

benefits of "any breastfeeding" vs. "exclusive breastfeeding;" the health risks of not breastfeeding; and strategies for Michigan to consider as the WIC Program works to close the gap between the Healthy People 2020 Goals for exclusive breastfeeding and Michigan WIC client data. Other breastfeeding related topics included using influence principles to change behaviors and the role and appropriate sizing of breast pump flanges.
Lactation Education Consultants returned to follow up the 2010 Lactation Management Course with hands-on training to help experienced staff become mentors to their colleagues and peer counselors in the local agencies.
Other Training included BF Basics, BF Coordinator, Milk Expression and Grow and Glow. Breastfeeding Basics Training was provided on 5 separate occasions, reaching over 160 individuals. Breastfeeding Coordinators from 8 local WIC agencies received training on their WIC role and milk expression (hand expression and the basic use and assembly of breast pumps along with trouble- shooting problems). The Grow and Glow Training components of communication and team building dynamics were incorporated into BF Basics Training. This has helped local agency staff become competent in the knowledge and delivery of breastfeeding promotion and support.
WIC organized a Breastfeeding Collaboration Workgroup in the Department of Community Health. The group meets every other month. We also collaborate with the Healthy Weight Partnership which is the CDC funded Obesity Prevention Grant. This grant has devoted a part-time position to keep breastfeeding support ongoing with a focus on policy change. WIC was an active participant in two Summits -- Obesity Prevention and Infant Mortality - where we advocated strategies to support breastfeeding as a critical player in decreasing infant mortality and preventing childhood obesity and overweight/obesity in postpartum women.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Supported BF peer counseling and training				X
2. Maintained BF Initiative partnership with Michigan State University				X
3. Supported Every Ounce Counts breastfeeding media campaign			X	
4. Provided lactation training for physicians, nurses and WIC staff to improve communnication between health care providers and mothers				X
5. Other Training Provided: BF Basics, BF Coordinator, Milk Expression, Grow and Grow				X
6. Organized a BF Collaboration Workgroup within the Department				X
7. Collaborated with Healthy Weight Partnership (CDC Obesity Prevention Grant)				X
8. Participated in statewide Obesity and Infant Mortality Summits in September and October 2011				X
9.				
10.				

b. Current Activities
Our State BF staff and contractors attended the revised USDA Loving Support Peer Counselor Curriculum training held in October 2011. We quickly incorporated the new technology into BF Basics Training.
The DCH Breastfeeding Collaborative Workgroup continued with representatives from the Maternal Infant Health Program, Medicaid and Disease Prevention. The Division is working with the Maternal & Child Health Council of Michigan to improve the availability of breast pumps for

Medicaid recipients, and with the Michigan BF Network to support breastfeeding through policy and legislation.
We participated in the DCH Director's meeting with the Capitol Area BF Coalition to strategize ways that we can complement each other's work.
We continue to tweak the MI-WIC data system to gather better information and produce more effective reporting.
Our BFI Partnership with MSUE continues despite a funding set-back. We are working with Extension to find alternate ways to reach our WIC clients.
Our WIC-based BF Peer Counselors now number nearly 100. The peer counselors will have a day-long continuing education opportunity with nationally recognized speaker, Jack Newman.
Building Bridges to Breastfeeding Duration is continuing this year as we partner with Detroit's Henry Ford Hospital and St. Joseph Mercy Hospital in Ann Arbor/Ypsilanti.
50 local WIC agency staff attended the Intensive Lactation Mgmt. Course in April.
A student intern is reviewing the BF lesson for updates and current linkages.

c. Plan for the Coming Year
We are looking forward to expanding our WIC clinic based Peer Counselor Program to all our agencies except one. Keweenaw Bay is a tiny agency and now has an IBCLC on staff to serve all pregnant and breastfeeding clients.

We are expanding the availability of board certified Lactation Consultants (LC) to our local agencies. Several local agency WIC staff have earned the IBCLC credential. Additionally, our contracted LCs are going to be available as back-up resources for our local WIC staff. The LCs will provide technical assistance when situations arise that require the expertise of someone outside the agency.

Building Bridges is being planned for four more locations in 2013.

Planning for the 2013 WIC Conference is about to commence.

A Hospital Summit on Breastfeeding is in the discussion stages.

More improvements in MI-WIC are in the planning process.

A Kellogg Grant has been received. This will allow for enhancement of the role of several BFI Peers in 2013 and the opportunity to conduct research comparing BF service delivery methods. There is a continued intent to establish a BF Coordinator for MDCH. This person could help identify needs, supports and build consensus within the Department. Establishment of such a position would provide a focal point within the Department regarding breastfeeding promotion efforts and help local community health programs work with their partners, and the public at large, to develop BF support through coalition building

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100
Annual Indicator	97.1	96.7	97.3	98.5	98.5
Numerator	119770	116318	112464	111491	111491
Denominator	123407	120240	115576	113153	113153

Data Source		EHDI Database	EHDI Database	EHDI Database	EHDI Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

Michigan EHDI has continued to have 100% of birthing hospital participation in universal newborn hearing screening. Pass and referral rates have remained fairly stable at roughly 99% (n=110,231/111,762) pass and 1.0% referred (1531/111,762) (of those who had a complete screen) in 2010. Of infants diagnosed with permanent hearing loss, 58.0% (n=84/144) were identified prior to 3 months of age in 2010. Of the infants identified with hearing loss, all with parent consent were referred to Part C services. Obtaining documentation of early intervention services continues to be problematic due to FERPA (Family Education Rights and Privacy Act) but for those cases that are reported as enrolled in services (n=44/144), 45% (n=20/44) received services prior to 6 months of age.

EHDI continues to provide resources and consultation to hospitals, increase public awareness through exhibiting and presenting, providing an annual EHDI conference, and providing an online hearing screener training module for hearing screeners, hospital nurse coordinators, and audiologists. EHDI continues to maintain provider lists for hospital, rescreen, diagnostic, and early intervention sites. Physician education and family support continues as a priority for EHDI staff time and resources. EHDI is continuing to develop and implement various stages of database development. Newborn hearing screening results continue to be displayed online for provider access via the Michigan Care Improvement Registry (MCIR). EHDI continues to receive referrals for a family support program called "Guide- By-Your-Side". This program links families with newly identified infants with hearing loss to other hearing loss families in order to provide family support through the initial stages of diagnosis to intervention.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Achieved 100% participation of birthing hospitals				X
2. Screened 109,280 infants	X			
3. Referred infants identified with hearing loss to Part C services		X		
4. Provided training, technical assistance and educational meetings				X
5. Provided family support		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Collaboration with the MCIR continues to be a priority. EHDI is proceeding with developing a web-based reporting system for hearing screening and diagnostic hearing testing on the MCIR system. EHDI has continued to maintain the follow-up system. EHDI continues to support the parent programs Guide-By-Your-Side and Michigan Hands & Voices.

c. Plan for the Coming Year
EHDI will collaborate with MCIR staff to develop a loss-to-follow up system to ensure tracking and surveillance of infants through screening, diagnostic, and intervention services. The program will continue providing hospitals with quarterly reports on screening efforts. EHDI materials will continue to be distributed for family and provider use. EHDI staff will make efforts to work closer with primary care providers to ensure follow-up care. A Request for Proposals will be sent to birthing hospitals to support the purchase of new screening equipment. The EHDI program will hold advisory meetings and obtain provider/family input into program operations and activities

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	3.5	4.5	6	6	4.6
Annual Indicator	4.7	4.7	4.7	4.6	4.1
Numerator	116049	113000	110445	107827	95103
Denominator	2445601	2390198	2349892	2344068	2331475
Data Source		2008 CPS	2008 CPS	2009 ACS	2010 ACS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	4.1	4	3.9	3.8	3.7

a. Last Year's Accomplishments
According to the American Community Survey, the uninsured rate for children under 18 was 4.1 in 2010, decreasing from 4.6 in 2009. According to the Kaiser Family Foundation State Health Facts, health insurance coverage of children 0-18 continued to decrease for employer-sponsored insurance and increase for public insurance coverage in 2010. The average monthly number of children receiving Medicaid benefits in 2011 increased by 10.3% over 2010.

Outreach activities continued to be carried out by local health departments and other community agencies, with consultation and technical assistance from the Michigan Department of Community Health. Efforts continued to identify additional community based partners and encourage them to participate in outreach and enrollment efforts. Eligibility levels for Medicaid services to children and the state's-CHIP program, MIChild, were maintained.

The state maintained coverage for children with chronic physical conditions and persons over 21 with cystic fibrosis and hereditary coagulation defects through the Children's Special Health Care Services program. The HRSA-funded family-centered medical home for CSHCN project concluded with 10 of the original practices indicating that they could continue the model. A new HRSA grant was awarded to implement the family-centered medical home model in a rural FQHC.

The State's pre-existing condition insurance plan, HIP Michigan, established under federal health care reform, was implemented in October 2010. The plan covers a broad range of health benefits including primary and specialty care, hospital care and prescription drugs. Two additional plans with the same benefits and lower monthly rates, but higher deductibles, were approved to begin May 2011. Premiums for the plan decreased by 10% effective October 2011.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued consultation and technical assistance to local health departments and other agencies on outreach activities				X
2. Continued recruitment of additional community partners for outreach				X
3. Maintained eligibility levels for Medicaid and MIChild (S-CHIP)				X
4. Maintained CSHCS program eligibility				X
5. Maintained and expanded state pre-existing condition insurance plan				X
6. Concluded CSHCN medical home model project				X
7.				
8.				
9.				
10.				

b. Current Activities

Outreach activities through local health departments and other local agencies continue with consultation and technical assistance from MDCH. Recruitment of additional community-based partners for outreach and enrollment continue. With the ongoing limitations in state revenues, the Department continues efforts to protect coverage levels for children through Medicaid and S-CHIP (MIChild).

Implementation of the FQHC medical home model for CSHCN in a rural area continues in the Alcona Health Center.

The HIP Michigan program continues to make coverage available for children and families with pre-existing conditions.

c. Plan for the Coming Year

Local health departments will continue to carry out extensive outreach activities under the Medicaid and MIChild programs. The Department will continue to provide consultation and technical assistance to local public health. Outreach and enrollment efforts to identify and encourage participation of community based partners will continue. The Department will continue to advocate for maintenance of current benefits and eligibility for Medicaid and MIChild.

The FQHC medical home project for CSHCN in rural Michigan will continue.

Under the Office of Financial and Insurance Regulation, implementation of provisions of federal health care reform will continue to be developed as further guidelines and funding are released.

As the home visiting programs, established under ACA, continue to be implemented, opportunities will be identified to encourage and assist with the enrollment of children into Medicaid and MIChild plans.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	15.8	29.5	29	28.5	29
Annual Indicator	29.5	30.1	30.3	29.6	29.9
Numerator	28255	29469	34690	31382	34686
Denominator	95780	97905	114489	106019	116006
Data Source		PNSS/PedNSS	PNSS/Ped/NSS	PNSS/PedNSS	PNSS/PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	29.5	30	31	32	32

a. Last Year's Accomplishments
WIC-Breastfeeding-Obesity Partnership: WIC continued to work with chronic disease to deliver client and professional messages about decreased later-life incidence of obesity by infants being breastfed.

Using USDA Peer Counseling Funds, allocations were made to more WIC agencies to hire breastfeeding peer counselors. With this initiative, there are now peer counselor services in all but 7 of the 83 Michigan counties, with 60 of the counties served by WIC-employed peer counselors, and the remaining 16 counties served by MSU Extension (WIC-funded) peers. Peer counselor services help with prevention of obesity by increasing the initiation and duration of exclusive breastfeeding.

Michigan WIC continues to address the paradox of obesity and food insecurity collaboratively with ongoing participation on the Michigan State Nutrition Action Committee (MiSNAC), the Michigan Breastfeeding Network, the Capitol Area BF Coalition and members of the DCH BF Collaborative Workgroup. Information shared on state-wide initiatives, programs and activities is communicated in various ways to promote local agencies consortiums and leverage nutrition education efforts.

WIC staff received training at the 2011state WIC conference on effective communication with overweight/obese clients: Counseling Parents of Overweight Children (Lockwood, Sallinen & Woolford,Univ of MI), Getting People to Say Yes (McCarthy) and Gestational Diabetes-Helping Clients to Better Outcomes (Traver, Michigan WIC).
In FY 2010-11, WIC clients had 24/7 internet access to 22 interactive lessons in English and Spanish on healthy eating and physical activity. Over 100,000 total lessons were completed; almost 20,000 were in 3 key topics related to healthy weight, i.e. Fruits & Veggies, Fun & Healthy Drinks, and Healthy Happy Active Children.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Partnered with Chronic Disease Program on Obesity prevention/reduction initiatives				X
2. Promote breastfeeding as a means to prevent childhood obesity and maternal weight reduction			X	
3. Participation in MI State Nutrition Action Committee to address obesity and food insecurity				X
4. Trained WIC staff on effective communication with overweight/obese clients				X
5. Maintained online lessons related to healthy weight			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
WIC children age 2-5 are measured & weighed at each certification appointment. Anthropometric measurements are plotted electronically and WIC staff continue to assess clients for BMI-related risks. Children presenting at high risk are referred to the Registered Dietitian for further intervention.

62,000 sets of the Sesame Street Eating Well on a Budget education tools addressing food insecurity, food access, & reduced calorie intake have been provided for local agency distribution to clients. The May 2012 statewide WIC Conference included several sessions for staff training on weight mgmt and obesity: Synergy Between the Primary Care Office and WIC: Growth Charts and Beyond (Chris Pohlod, DO, FACOP, FAAP); Childhood Obesity: Tackling a Weighty Subject (Lynne DeMoor, MS, RD); and Food Policy, Nation to Your Plate (Diane Golzynski, PhD, RD).

Several Advanced CPA training sessions focusing on effective counseling skills related to client behavior mgmt have been offered at various locations around the state. There were 471,000 nutrition education encounters through wichealth.org. Multiple wichealth.org system enhancements are underway to optimize the online nutrition education experience for WIC clients. Michigan is one of two states nationally whose WIC clients are invited to participate in a text message pilot upon completing the wichealth.org Fruits and Veggies for Kids lesson, showing a positive impact on client intent to consume fruits & vegetables & reported behavior change

c. Plan for the Coming Year

Michigan WIC continues to initiate and support exclusive breastfeeding to prevent obesity. If funding is available, breastfeeding peer counseling services will be expanded to all remaining counties except Keweenaw. Michigan WIC plans to continue sponsoring Breastfeeding PSA's to be aired throughout the state.

The WIC Division will continue to offer quality training opportunities for staff and enhance the wichealth.org learning environment in order to offer WIC clients nutrition education surrounding prevention and treatment of overweight and obesity. Several additional Advanced CPA training sessions on effective counseling will be offered at various locations around the state in 2012. Opportunities to collaboratively support state-wide nutrition initiatives and leverage nutrition/physical education will continue to be promoted at various levels. For example, the United Dairy Industry of Michigan will be generously providing WIC clinic nutrition education teaching resources in 2012.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	13.6	12.6	16.8	16.7	15.2
Annual Indicator	17.1	15.4	17.8	15.2	
Numerator	21371	18699	20087	17244	
Denominator	125172	121231	112805	113446	
Data Source		PRAMS	PRAMS	PRAMS	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	15.1	15.1	15	15	15

Notes - 2011

Data collection is ongoing for 2011 PRAMS. Estimates were not generated due to recent changes in state smoking policies, the fluctuations in PRAMS estimates due to sample size, and the lack of data for prior year.

Notes - 2010

2010 PRAMS data are still being weighted by CDC and are not available to Michigan at this time. The 2010 provision estimate entered in the 2012 application was not updated.

Notes - 2009
2009 Data included for submission for the 2013 application: the numerator was the number of women reporting that they smoked any cigarettes during the third trimester of pregnancy. The denominator is all women who answered the question on the 2009 PRAMS survey.

a. Last Year's Accomplishments
With the enforcement of our new smoke free air law along with a continued emphasis on smoking cessation, the MDCH Tobacco Programs hope that the prevalence of smoking will continue to decrease in the coming years.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Developed web-based Smoke Free Baby and Me (SFBM) training.			X	
2. Provided Continuing Education Credits to participants completing and passing the web-based training.			X	
3. Made prenatal Quit-kits available to consumers and providers.		X		
4. Instituted SFBM web-base training as requirement for Maternal Infant Health Program (MIHP) staff.				X
5. Developed MIHP home-visiting program policy requirements for intervention on both tobacco use and exposure to tobacco smoke.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Smoke Free for Baby and Me (SFBM) training has continued to be offered as a web-based online requirement for all MIHP providers statewide. The SFBM program is designed to address the risk of smoking tobacco in pregnant women and mothers of infants in order to decrease the percentage of women who smoke during pregnancy and expose their infants to second-hand smoke. During 2010-2011, efforts to accelerate progress toward decreasing the percentage of women who smoke during the last 3 months of pregnancy included statewide policy and system changes: (1) legislation, effective May 1, 2010, to ban smoking in public places and (2) the development of MIHP home visiting program policy requirements for intervention on both tobacco use and exposure to second-hand smoke.

c. Plan for the Coming Year
Expansion plans for the Smoke Free Baby and Me (SFBM) program for 2012-2013 will include the collection and monitoring of data on the number of women smoking during pregnancy to identify potential gaps and/or barriers in service delivery and to inform the program of potential changes needed for further development. An additional web-based training on tobacco in pregnancy will be promoted to MIHP providers statewide. Completion of the update online training will provide both Nursing and Social Work continuing education credits.
For 2012-2013 continue work with partners in moving forward with the summit recommendation.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	7.8	7.7	7.3	7.3	7.2
Annual Indicator	7.0	7.3	7.8	9.9	6.6
Numerator	52	54	58	73	49
Denominator	745908	739588	739588	739599	739599
Data Source		MI Vital Records	MI Vital Records	MI Vital Records	MI Vital records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	7.2	7.2	7.2	7.2	7.2

a. Last Year's Accomplishments
The MDCH Injury and Violence Prevention Section completed the second year of activities related to its three year youth suicide prevention cooperative agreement from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The Department had a 0.5 FTE working specifically on the activities, including community technical assistance and eight continuing grants for local programs. Nine mini-grants were awarded to support local Applied Suicide Intervention Skills Training (ASIST) workshops and Assessing and Managing Suicide Risk (AMSR) trainings.

MDCH and Michigan Association for Suicide Prevention continue to work cooperatively on implementation of the state's suicide prevention plan.

The Department, on request, continued to offer technical assistance to local human services collaborative bodies and community mental health agencies across the state to develop local suicide prevention coalitions and plans.

The Michigan Model for Comprehensive School Health Education continued to be used in Michigan public, charter, and private schools. The curriculum promotes life skills for children and youth in grades K--12 in areas such as problem solving/decision making, resolving conflict, anger management, healthy lifestyles, listening skills, and feelings.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implementation of activities funded under the SAMHSA state youth suicide prevention cooperative agreement.		X		
2. Continued implementation of the Michigan Model for			X	

Comprehensive School Health.				
3. Implementation of the state suicide prevention plan.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The MDCH Injury and Violence Prevention Section is continuing to support training and local program grants for activities across the state. Section staff will be conducting a series of listening sessions across Michigan to learn about local views on youth suicide prevention and suicide prevention overall. Staff are also continuing to provide ongoing technical assistance to local and regional suicide prevention efforts as requested.

Implementation of the Michigan Model is ongoing.

c. Plan for the Coming Year
The Injury and Violence Prevention Section will be requesting a no-cost extension to complete the activities proposed to SAMHSA for its current youth suicide prevention grant, specifically holding a statewide community technical assistance meeting for all persons interested in suicide prevention.

Implementation of the Michigan Model will be ongoing.

Activities will continue toward implementation of the state plan for suicide prevention. The plan is also scheduled to be updated and revised.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	88.4	88.4	80	80	82
Annual Indicator	85.0	78.0	85.2	85.2	85.5
Numerator	1826	1708	1646	1617	1538
Denominator	2147	2191	1931	1897	1799
Data Source		MI Vital Records	MI Vital Records	MI Vital Records	MI Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	85	85	86	86	87

a. Last Year's Accomplishments

The governor has made infant mortality a priority strategy. An infant mortality Summit was held in October of 2011. One of the 7 priority strategies that were identified through stakeholder input is to re-instate perinatal regionalization in the state.

In September 2011, a stakeholder meeting was held. The stakeholders were charged with providing expertise and guidance in the development of Administrative Rules for Perinatal Regionalization. Subcommittee workgroups were formed to work on components of administrative rules for a statewide perinatal coordinated system. Seven workgroups were recommended: 1) Designation-Verification-Certification; 2) Triage-Transport-Destination; 3) Quality Assurance, Data Management, Evaluation; 4) Education-Training-Communication; 5) NICU follow up; 6) Maternal follow up and 7) Preconception/interconception care. Two additional workgroups were recommended, but have not met yet.

Three pilot projects for perinatal regionalization were implemented. The first project was a Vermont Oxford Network (VON) Neonatal Quality Improvement initiative, called the Michigan Collaborative Quality initiative (MICQI). In April of 2011, MICQI hosted a quality improvement training for participating centers which was well attended. There are 15 out of the 20 hospitals with NICU designation that belong to the MICQI. The second pilot project is a NICU follow up clinic project in 3 counties. The NICU follow up clinic consists of two components: a developmental assessment clinic (DAC) and a home visitation component. A nurse clinical coordinator was hired and began in February 2011. The three counties had DACs in operation by March of 2011. The third pilot is in the northern lower region of Michigan and encompasses the development of a regional perinatal system in that area. MDCH is a catalyst to create OB services in underserved portions of Michigan.

The development of a regional perinatal system helps assure that the right patient gets the right care at the right time. Designation and verification policies at birth hospitals, as well as destination, triage and transport policies that collaborate with the EMS system help to facilitate the birth of very low birth weight and premature infants at the appropriate facility for their ne

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitored data of low birth weight infants delivered at high-risk facilities to assure system of referral is working				X
2. Determine communities with racial disparities in infant mortality have significant percentages of VLBW infants born in hospitals without a NICU				X
3. Develop recommendations for statewide coordinated perinatal system				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Five of the seven workgroups convened to develop a state wide perinatal system and to develop administrative rules related to time dependent emergencies in collaboration with the EMS system. The five workgroups that met include: 1) Designation-Verification-Certification; 2) Triage-Transport-Destination; 3) Quality Assurance, Data Management, Evaluation; 4) Education-Training-Communication; and 5) NICU follow up. The five workgroups made recommendations for developing the statewide coordinated perinatal system. The recommendations and next steps were presented to stakeholders in May 2012 with overwhelming positive feedback.

The three pilot projects continued. MICQI hosted a second quality improvement training related to creating a positive patient safety culture in the NICU in May 2012.This year there has been a focus on the development of the NICU follow up home visitation project, which will utilize two state programs (Maternal Infant Health Program and Children's Special Health Care Services). The northern region of the state continued meetings toward regionalized perinatal care. A regional FIMR team is recommended for the area.

Currently there are limited funds allocated for perinatal regionalization in the budget, and the department is waiting for final approval of the infant mortality budget

c. Plan for the Coming Year
After the positive feedback from the stakeholder meeting in May 2012, MDCH will convene an internal group to gain administrative support. Work with other departments such as Certificate of Need and the EMS/trauma system will continue as the work of development of regionalized perinatal care continues. Establishment of the structure and processes will be important next steps for a statewide perinatal coordinated system. A summit is planned in the northern lower region to move forward with perinatal regionalization in the area. The structure and recommendations from this group may serve as a model for other regions of the state.

Convening the remaining two workgroups related to maternal follow up and preconception/interconception care will facilitate risk assessment, early entry into prenatal care and other strategies to identify high risk women earlier. The department is applying for a Strong Start grant to reduce preterm birth. Additional data from FIMR teams continue to be essential in developing strategies to reach women who have a history of poor pregnancy outcomes. Fiscal resources will continue to be a challenge.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	89	90.3	90.3	90.3	75
Annual Indicator	81.5	73.2	73.5	74.3	74.6
Numerator	102050	88791	85762	85269	84133
Denominator	125172	121231	116610	114717	112738
Data Source		MI Vital Records	MI Vital Records	MI Vital Records	MI Vital records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	75	76	77	80	82

a. Last Year's Accomplishments

The number of women receiving prenatal care in the first trimester has not made much progress in the previous years. A number of systems problems contribute to this challenge.

In October, 2011, an Infant Mortality summit was held in which stakeholders provided input for seven priority strategies. One strategy is to screen cervical length and provide treatment with vaginal progesterone. Screening needs to occur prior to the 20th week of gestation and treatment begun prior to 24 weeks gestation.

The state has moved forward with plans for a statewide perinatal coordinated system. MDCH is a catalyst to create OB services in underserved portions of Michigan. A workgroup in northern Michigan was created with prenatal care as a priority area.

An interagency planning initiative to integrate prenatal alcohol exposure prevention, intervention and service linkage for pregnant women, children and families affected by FASD began in the summer 2011. MDCH is the lead to begin interagency integration among key state programs and FASD Diagnostic Centers.

The five Nurse Family Partnership (NFP) projects continued services with funding from state, federal, Medicaid match, foundations and local contributions. Four additional programs are in planning in Ingham, Detroit, Saginaw and Flint. These programs will have the same mixture of funding used to initiate these projects.

The Medicaid Family Planning Waiver continued with increased outreach and assistance for FQHCs and other providers.

Michigan's Maternal Infant Health Program (MIHP) has initiated the process to become evidenced based home visitation model including improving staff training, evaluation fidelity to model and assessing population outcomes using a quasi-experimental design. MIHP continues to provide care coordination home visitation services to pregnant women and infants with Medicaid insurance. Currently there are 120 MIHP agencies in all Michigan counties. Programs are housed in local health departments, tribal communities, FQHC's, hospital based clinics and in private agencies. Service is provided with a population management, care coordination approach. Focus in the past year has been on fidelity to model, certification enhancement, standardized documentation & research based data collection. Quality assurance measures have been enhanced in order to assure that services are consistently implemented in the varied programs throughout the state.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Movement of the Maternal Infant Health Program (MIHP) towards becoming an evidenced based model including efforts to assure model fidelity. Continued evaluation and data analysis will assist with identifying best practices for improving early entry t		X		

2. Collaboration with multiple referral pathways through women & family programs to promote access & encourage early prenatal care being in the first trimester: MIHP, WIC, Plan First, MOMS, NFP, Healthy Kids for Pregnant Women, LIF				X
3. The Nurse family Partnership projects will continue enrolling clients and offer early intervention for first time pregnancies	X			
4. Plans to analyze data collected from the pilot prenatal projects and the NFP sites to learn best practices for improving early entry to prenatal care				X
5. Plans for the department to look at ways to study how much substance abuse occurs in childbearing age women and how inadequate contraception affects the timing of entry to care and ways to affect Medicaid and health plan policies to reward early.				X
6. Revision of MQIC Guidelines For Unintended Pregnancy that emphasize connection and referral to primary care providers, local health department, family planning clinics, Plan First, and federally qualified health centers (FQHCS).				X
7. Develop strategies for cervical length screening and appropriate treatment with vaginal progesterone.			X	
8.				
9.				
10.				

b. Current Activities
Strategies to get women into prenatal care during the first trimester continue to be explored as part of the infant mortality reduction plan.

Workgroups related to the development of a statewide perinatal system convened and made recommendations to stakeholders in May 2012. A regionalized perinatal care system can assess and implement strategies that overcome barriers to access into first trimester prenatal care.

NFP sites are being expanded through a home visitation grant and state funding which will bring the total to 9 sites where the program is provided.

Title X Family Planning and Medicaid Family Planning Waiver activities continue. Healthy Kids For Pregnant Women Program provides health care for pregnant women of any age. Maternity Outpatient Medical Services program provides immediate prenatal care while a Medicaid application is pending and for teens who chose not to apply for Medicaid.

MIHP has been working with state and local partners to enhance the perinatal service delivery system for pregnant women and infants. Local MIHP agencies have worked to develop more formal relationships with prenatal care providers and agencies serving the population. Data is collected regarding entry into prenatal care on the maternal risk identifier--the standardized tool used to assess all pregnant MIHP beneficiaries.

c. Plan for the Coming Year
MDCH will convene an internal group to gain administrative support for perinatal regionalization. Work with other departments such as Certificate of Need and the EMS/trauma system will continue as the work of development of regionalized perinatal care continues. Establishment of the structure and processes will be important next steps for a statewide perinatal coordinated system.

Strategies to promote cervical screening and progesterone treatment will continue to develop. These strategies will promote early access into prenatal care.

Title X Family Planning and Medicaid Family Planning Waiver activities will continue.

New NFP sites will be serving clients and funding will continue for all programs.

MIHP Activity in 2013 will focus on gathering and synthesizing discharge data regarding women who entered into prenatal care at or beyond 14 weeks. Reports generated from this data and the associated analysis will assist the MIHP team as they move forward in addressing the entry into care and its effect on birth outcomes.

D. State Performance Measures

State Performance Measure 1: *Percent of pregnancies that are intended*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					54.7
Annual Indicator		55.0	55.4	54.8	
Numerator		66645	62563	62168	
Denominator		121231	112855	113446	
Data Source		PRAMS	PRAMS	PRAMS	
Is the Data Provisional or Final?				Provisional	
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	54.7	54.6	54.6	54.5	54.5

Notes - 2011
Data collection is on-going for 2011 births using the PRAMS survey. Given the recent reduction in population of women of reproductive age in Michigan, we chose not to estimate this figure using vital records data.

2010 remains provisional as the PRAMS data are still being weighted by CDC and the final file has not been provided to Michigan.

Notes - 2010
The numerator is for PRAMS and teh denominator is the number of live births reported by vital records. We don't have 2009 PRAMS data to make further estimates so we can only calculate the expected number by using the number of live briths reported by vital records for 2009 and 2010; hence the decision to use vital records live births as denominator and not the estimated number of live births from PRAMS.

Notes - 2009
In 2012 application submission, The numerator is for PRAMS and teh denominator is the number of live births reported by vital records. We don't have 2009 PRAMS data to make further estimates so we can only calculate the expected number by using the number of live briths reported by vital records for 2009 and 2010; hence the decision to use vital records live births as denominator and not the estimated number of live births from PRAMS.

For the 2013 application submission, PRAMS data were available so we updated the numbers for 2009. The numerator is the weighted frequency of women who responded that they wanted to be

pregnant sooner or then just before the woman found out she was pregnant. The denominator is the weighted number of women who responded to the pregnancy timing question..

a. Last Year's Accomplishments
Funding for Michigan's Title X Family Planning Program includes Title X Federal grant, state appropriation, and other Federal fund sources. Due to ongoing reductions in state revenues and Federal (Title X and others) funding sources, the Michigan budget for FY 2011-2012 severely reduced state funding for family planning services. The state appropriation for local program allocations for family planning services was reduced by $939,300 for FY 2011-2012 which follows a decrease of $3,005,244 in the previous fiscal year. Family Planning delegate agencies also face cuts in local funding as communities and businesses struggle to survive in Michigan's economy. As a result of the funding reductions, local delegate agencies have been forced to scale back their family planning programs by closing clinics, reducing hours, and/or reducing staff. MDCH has taken steps to maximize resources and minimize our caseload loss and have implemented an Office of Population Affairs approved change in scope that reduces the number of minimally required contraceptives available onsite as well as some other cost savings.

Michigan's 120 Maternal Infant Health Programs (MIHP) continue to screen pregnant and postpartum women with births paid for by Medicaid insurance. The tools used are evidenced based and examine a woman for family planning related risks. If a risk exists, standardized care coordination interventions are provided and the woman is encouraged to utilize local family planning resources. Discussion of family planning is required at every MIHP home visit unless the woman has had a permanent sterilization method.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided Family Planning services statewide.		X		
2. All MIHP beneficiaries are screened for family planning risk during pregnancy and post-partum; are provided standardized reproductive health information and are referred to a family planning provider.		X	X	
3. Family Planning is required by Medicaid policy to be discussed at each MIHP visit.		X	X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Michigan's Title X family planning delegate agencies provided services to 24,764 teens were served including 24,232 females and 532 males. Currently 23.4% of the caseload is teens (24,764 of 105,777 clients).

The Michigan Department of Community Health (MDCH)/Medical Services Administration prepared and submitted a State Plan Amendment (SPA) for family planning services. This SPA will replace Michigan's Plan First! (Section 1115 Family Planning Demonstration Waiver). If approved by the Centers for Medicare and Medicaid Services, MDCH will also increase the range of family planning services offered and expand payment for services to men.

All beneficiaries in the MIHP program continue to be provided family planning information and referral to a reproductive health provider network. The program's evidence based/standardized interventions focus on reducing unintended pregnancy and interconception care.

c. Plan for the Coming Year
MDCH/Family Planning Program continues to make available general reproductive health assessment, comprehensive contraceptive services, related health education and counseling, and referrals as needed to every citizen of the state.

Building on the evidence based maternal and infant risk identifiers, standardized interventions and web based training provided for MIHP agencies around family planning and interconception care, MIHP activity in 2013 will focus on gathering and synthesizing discharge data regarding women who screened at risk. Risk level at screening, highest interim risk and risk level at summary will be entered into the state data base as well as documentation regarding standardized interventions were used to address the family planning concern identified. Reports generated from this data and the associated analysis will assist the MIHP team as they move forward in addressing ways to improve family planning in the population of women with births paid for by Medicaid.

State Performance Measure 2: *Percent of low birthweight births (<2500 grams) among live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	8.1	8	7.9	7.8	7.8
Annual Indicator	8.4	8.7	8.4	8.4	8.4
Numerator	10550	10543	9846	9685	9416
Denominator	125172	120601	117309	114717	112738
Data Source		MI Vital Records	MI Vital Records	MI Vital Records	MI Vital Records
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	8.4	8.3	8.2	8.1	8

a. Last Year's Accomplishments
The percentage of low birth weight babies (LBW) born in the previous five years has remained fairly consistently at 8.4% in Michigan. Low birth weight, along with prematurity, has remained the leading cause of infant death. The Michigan infant mortality rate among low birth weight infants is 26 times higher than normal weight infants and has decreased significantly in the past decade. Many factors contribute to the birth of low birth weight infants. Babies with congenital anomalies or chromosomal abnormalities are often associated with low birth weights. Placental problems and maternal infections contribute to low birth weight infants. Additional maternal risk factors that may contribute to low birth weight include multiple pregnancies, previous low birth weight infants, poor nutrition, heart disease or hypertension, smoking, drug addiction, alcohol abuse, lead exposure and insufficient prenatal care. Low birth weight is more common in women less than 17 years and more than 35 years.

Population strategies in Michigan to reduce low birth weight births include alcohol prevention strategies through the Fetal Alcohol Syndrome Disorder program, Smoking Cessation program which supports a tobacco Quitline to help women reduce or stop smoking during pregnancy and home visitation programs to support women during pregnancy and complement provider prenatal care visits such as through the five Nurse Family Partnership (NFP) programs and through the Maternal Infant Health Program (MIHP).
The Fetal and Infant Mortality Review (FIMR) program continued in 14 communities in Michigan, providing an important source of data to describe significant social, economic, cultural, safety, health and systems factors that contribute to infant mortality and low birth weight, and to design and implement community-based action plans founded on the information obtained from the reviews.

The governor has made infant mortality a priority strategy. An infant mortality Summit was held in October of 2011. Several strategies were identified that help to reduce low birth weight babies: improve preconception health, reduce unintended pregnancy, eliminate medically unnecessary deliveries prior to 39 weeks gestation, prevention of preterm deliveries through cervical length screening and progesterone treatment and restoration of the regional perinatal system and implementation of NICU follow up clinics. In addition, strategies to reduce the disparity in black/white birth outcomes remains a priority.

Michigan's Maternal Infant Health Program (MIHP) has initiated the process to become evidenced based home visitation model including improving staff training, evaluation fidelity to model and assessing population outcomes using a quasi-experimental design. MIHP continues to provide care coordination home visitation services to pregnant women and infants with Medicaid insurance. Currently there are 120 MIHP agencies in all Michigan counties. Programs are housed in local health departments, tribal communities, FQHC's, hospital based clinics and in private agencies. Service is provided with a population management, care coordination approach. Focus in the past year has been on fidelity to model, certification enhancement, standardized documentation & research based data collection. Quality assurance measures have been enhanced in order to assure that services are consistently implemented in the varied programs throughout the state.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided smoking cessation services and supported tobacco quitline.		X		
2. Implemented and monitored the progress of FAS prevention program to target high-risk families.		X		
3. Continued MIHP program that targets high-risk pregnant women and infants.		X		
4. Continued MIHP collaboration with WIC to identify clients and improve nutrition and weight gain.		X		
5. The Infant Mortality Initiative will continue to address the disparity in African American infant mortality rates in Michigan.				X
6. Nurse Family Partnership program continues to enroll and serve low-income, first-time pregnant women.	X			
7. Implement the recommendations in the Perinatal Regionalization: Implications for Michigan report.				X
8.				
9.				
10.				

b. Current Activities

Developing a statewide perinatal coordinated system has been a priority this year. Five workgroups convened and made recommendations at a stakeholder meeting in May 2012. These recommendations look at the lifecourse spectrum and emphasize the importance of preconception and prenatal care, which help to reduce LBW infants. A perinatal system assures the right patient gets the right care at the right facility.

FIMR activity continued in 14 communities. The Smoking Cessation and tobacco quitline continues. Fetal Alcohol Spectrum Disorder program continues to have community-based projects that provide local prevention and link to services as well as training and consultation state wide to eliminate alcohol exposure during pregnancy. NFP sites are being expanded through a home visitation grant and state funding which will bring the total to 9 sites where the program is provided.

The MIHP program continues to be a source of risk identification for pregnant women with births paid for by Medicaid. The program has evidence based risk identification, standardized care coordination interventions for biopsychosocial risks associated with pregnancy and infancy. Interventions address access to prenatal care, family planning, substance abuse and mental health as well as chronic disease and basic needs.

Practices to reduce infant mortality through equity (PRIME) received additional funding for 3 years. PRIME focused on training department employees so that institutional racism can be reduced.

c. Plan for the Coming Year

After the positive feedback from the stakeholder meeting in May 2012, MDCH will convene an internal group to gain administrative support. Work with other departments such as Certificate of Need and the EMS/trauma system will continue as the work of development of regionalized perinatal care continues. Establishment of the structure and processes will be important next steps for a statewide perinatal coordinated system.

Convening the remaining two workgroups related to maternal follow up and preconception/interconception care will facilitate risk assessment, early entry into prenatal care and other strategies to identify high risk women earlier. The department is applying for a Strong Start grant to reduce preterm birth. Additional data from FIMR teams continue to be essential in developing strategies to reach women who have a history of poor pregnancy outcomes. There are plans to develop a regional FIMR network in northern lower Michigan. FASD activities will continue. New NFP sites will be serving clients and funding will continue for all programs.

Building on the evidence based maternal and infant risk identifiers, standardized interventions and web based training provided for MIHP agencies around domains of risk, MIHP activity in 2013 will focus on gathering and synthesizing discharge data regarding pregnant and postpartum women and infants. Risk level at screening, highest interim risk and risk level at summary will be entered into the state data base as well as documentation regarding standardized interventions were used to address the concern identified. Reports generated from this data and the associated analysis will assist the MIHP team as they move forward in addressing ways to improve birth and health outcomes in the population of women with births paid for by Medicaid.

Fiscal resources will continue to be a challenge.

State Performance Measure 3: *Percent of preterm births (<37 weeks gestation) among live births*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	10.9	10.2	10.2	10.1	10.1
Annual Indicator	10.0	10.9	9.8	9.8	9.5
Numerator	12523	13141	11542	11205	10701
Denominator	125172	120601	117309	114717	112738
Data Source		MI Vital Records	MI Vital Records	MI Vital Records	MI Vital records
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	9.5	9.5	9.4	9.3	9.2

a. Last Year's Accomplishments

One in eight babies are born prematurely in Michigan with serious consequences for infant morbidity and mortality. The infant mortality rate among preterm infants is 17 times higher than infants born of normal weight and has increased significantly in the past decade. The increase in births in the late preterm period, between 34 and 37 weeks gestation was primarily responsible for the increase in preterm births in the previous decade. In 2009, 6.6% of the births were between 34 -- 37 weeks gestation, while 3.2% were less than 34 weeks. Prematurity and low birth weight remain the leading cause of infant death in Michigan.

Preterm birth is a complex issue and not fully understood. Major risk factors for preterm birth include a history of preterm birth, multiple gestation, smoking during pregnancy, inadequate prenatal care and being a relatively younger or older mother. Black infants are 70% more likely to be born prematurely than white infants and contributes to the significant black/white disparity in infant mortality.

Population strategies in Michigan to reduce preterm births include alcohol prevention strategies through the Fetal Alcohol Syndrome Disorder program, Smoking Cessation program which supports a tobacco Quitline to help women reduce or stop smoking during pregnancy and home visitation programs to support women during pregnancy and complement provider prenatal care visits such as through the five Nurse Family Partnership programs (NFP) and through the Maternal Infant Health Program (MIHP).

The Fetal and Infant Mortality Review (FIMR) program continued in 14 communities in Michigan, providing an important source of data to describe significant social, economic, cultural, safety, health and systems factors that contribute to infant mortality and preterm birth, and to design and implement community-based action plans founded on the information obtained from the reviews.

Michigan's Maternal Infant Health Program (MIHP) has initiated the process to become evidenced based home visitation model including improving staff training, evaluation fidelity to model and assessing population outcomes using a quasi-experimental design. MIHP continues to provide care coordination home visitation services to pregnant women and infants with Medicaid insurance. Currently there are 120 MIHP agencies in Michigan's 83 counties. Programs are housed in local health departments, tribal communities, FQHC's, hospital based clinics and in private agencies. Service is provided with a population management, care coordination approach. Focus in the past year has been on fidelity to model, certification enhancement, standardized documentation & research based data collection. Quality assurance measures have been

enhanced in order to assure that services are consistently implemented in the varied programs throughout the state.

The governor has made infant mortality a priority strategy. An infant mortality Summit was held in October of 2011. Several strategies were identified that help to reduce preterm babies: improve preconception health, reduce unintended pregnancy, eliminate medically unnecessary deliveries prior to 39 weeks gestation, prevention of preterm deliveries through cervical length screening and progesterone treatment and restoration of the regional perinatal system and implementation of NICU follow up clinics. In addition, strategies to reduce the disparity in black/white birth outcomes remains a priority.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue the MIHP program that serves all pregnant women who have Medicaid insurance with a focus on model fidelity, data collection and analysis and movement towards an evidence based model.	X			
2. Re-establish the Perinatal Regional System of care.				X
3. Continue the Medicaid Family Planning Waiver program to reduce unintended pregnancies.	X			
4. Nurse Family Partnership encouraged early enrollment to provide education on preterm birth.		X		
5. Continued to analyze statewide FIMR data and inform programs on characteristics associated with prematurity.				X
6. Implement the MDCH Infant Mortality Strategic priority strategies: reduce elective births <39 weeks gestation and implement cervical screening and progesterone treatment as indicated.				X
7.				
8.				
9.				
10.				

b. Current Activities

Perinatal regionalization development is a priority. Five workgroups met and made recommendations at a May 2012 stakeholder meeting. Two strategies from the infant mortality reduction plan specifically target preterm births: elimination of elective births prior to 39 weeks & cervical length screening with progesterone treatment if indicated. 86% of birth hospitals participate in a quality initiative related to the elimination of elective births prior to 39 weeks. FIMR activity continued in 14 communities. The Smoking Cessation and tobacco quitline continues. Fetal Alcohol Spectrum Disorder program has community-based projects that provide local prevention and link to services as well as training and consultation state wide to eliminate alcohol exposure during pregnancy. NFP sites expanded to 9 sites to assist first time mothers.

The MIHP program continues to be a source of risk identification for pregnant women with Medicaid insurance and has been working with state and local partners to enhance the service delivery system for pregnant women and infants. Local MIHP agencies have worked to develop more formal relationships with prenatal care providers and agencies serving the population. Data is collected on the maternal risk identifier which is then utilized to develop a care plan to address those risks. The team of nurse, social worker, registered dietitian and infant mental health specialists then provide standardized interventions to address the identified risk.

c. Plan for the Coming Year
Establishment of the structure and processes will be important next steps for a statewide perinatal coordinated system. Convening two workgroups for maternal follow up and preconception/interconception care will facilitate risk assessment, early entry into prenatal care and other strategies to identify high risk women earlier. The department is applying for a Strong Start grant to reduce preterm birth.

Additional data from FIMR teams continue to be essential in developing strategies to reach women who have a history of poor pregnancy outcomes. There are plans to develop a regional FMIR network in northern lower Michigan. FASD activities will continue. Continue all NFP programs in the 9 communities.

Building on the evidence based maternal and infant risk identifiers, standardized interventions and web based training provided for MIHP agencies around domains of risk for pregnant women and infants, MIHP activity in 2013 will focus on gathering and synthesizing discharge data regarding the women who screened "at risk". Risk level at screening, highest interim risk and risk level at summary will be entered into the state data base as well as documentation regarding standardized interventions were used to address the maternal or infant concern identified. Reports generated from this data and the associated analysis will assist the MIHP team as they move forward in addressing ways to improve maternal and infant health outcomes in the population of women with births paid for by Medicaid.

Fiscal resources will continue to be a challenge.

State Performance Measure 4: *Percent of singleton births by mother's BMI at start of pregnancy greater than 29.0*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					25.5
Annual Indicator			24.6	25.5	24.7
Numerator			26614	26413	26807
Denominator			108019	103778	108692
Data Source			MI Vital Records	MI Vital Records	MI Vital Records
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	25.5	25	24	23	22

a. Last Year's Accomplishments
Michigan's 120 Maternal Infant Health Programs (MIHP) continue to screen pregnant and postpartum women with births paid for by Medicaid insurance. The tools used are evidenced based and examine a woman for food and nutrition risks. If a risk exists, standardized care coordination interventions are provided. Every pregnant or postpartum woman and infant in MIHP is referred to WIC. WIC provides nutritional information during pregnancy and high risk counseling by a Registered Dietitian. MIHP also promotes breastfeeding which is linked to healthy weight in postpartum women.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promotion of healthful eating and physical activity through NPAO community interventions.			X	
2. Promote Health weight gain during pregnancy through MIHP and WIC.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Eligible women are referred to the WIC program which provides nutritional information during pregnancy including "health hints" for pregnant women. Promotion of breastfeeding and related support also occurs which is linked to healthy weight in women.

MIHP staff continue to use standardized risk identifiers and interventions to assess and address nutrition and food access needs. The Registered Dietician is an important member of the MIHP service provision team. If a MIHP does not have a RD on staff they are required to submit a referral plan to a local dietitian. MIHP also has a Master's of Public Health intern on staff. Her summer project is to gather research regarding breastfeeding, synthesize the information and create standardized breastfeeding interventions, training and education materials for the MIHP programs to use. The student is working closely with state WIC, Perinatal regionalization, MIHP providers and Michigan State University.

c. Plan for the Coming Year
Eligible women will continue to be referred to the WIC program which provides nutritional information during pregnancy including "health hints" for pregnant women. Promotion of breastfeeding and related support also occurs which is linked to healthy weight in women.

The 120 MIHP providers in the state will continue to ask every enrolled beneficiary (over 30,000 pregnant women and their babies each year) if they are enrolled in WIC. If they are not enrolled a referral with follow up will be made. All beneficiaries will be screened for nutrition risks and will be provided standardized interventions if a risk is identified. Risk level at screening, highest interim risk and risk level at summary will be entered into the state data base as well as documentation regarding standardized interventions were used to address the concern. Reports generated from this data and the associated analysis will assist the MIHP team as they move forward in addressing the effect of nutrition risks on the health outcomes of pregnant women and infants.

State Performance Measure 5: *Ratio between black and white children under 6 years of age with elevated blood lead levels*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011

Annual Performance Objective					3.2
Annual Indicator		3.5	3.4	3.8	2.9
Numerator		1090	896	816	576
Denominator		308	263	216	202
Data Source		MDCH Data Warehouse	MDCH Data Warehouse	MDCH Data Warehouse	MDCH Data Warehouse
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	3	2.8	2.6	2.4	2.2

a. Last Year's Accomplishments

No progress has been made linking lead data with MCIR race/ethnicity, but lead data was again linked with Medicaid beneficiary race/ethnicity, supplementing race/ethnicity collected directly through blood lead analysis reporting.

The number and percentage of black children under 6 years of age with elevated blood lead levels (EBLL) decreased dramatically from 2010 to 2011--from 816 (1.8%) to 202 (1.3%). The ratio between black and white children with EBLL went from 3.8 to 2.9.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Request access to race data in MCIR or in the MDCH data warehouse.				X
2. Develop and test methodology for linking race data with lead testing results.				X
3. Develop and produce regular reports that help to assess Michigan's status for this performance measure.				X
4. Based on results of analysis, assess need to modify state's lead testing plan to address any disparities identified.				X
5. Based on results of analysis, identify other strategies for addressing any disparities identified.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

This information will be included in a 2011 data report on Lead in Michigan. Our Advisory Group is addressing racial disparities in the development of our Strategic Plan for Healthy Homes.

c. Plan for the Coming Year

Request access to race data in MCIR via MDCH Data Warehouse. Develop and test methology for linking race data with lead testing results. Develop and produce regular reports that help to assess Michigan's status for this performance measure. Based on results of analysis, assess need to modify state's lead testing plan to address any disparities identified and identify other strategies for addressing disparities.

State Performance Measure 6: *Rate per 100,000 of Chlamydia cases among 15-19 year-olds*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					2800
Annual Indicator		2,670.1	2,780.7	2,745.0	2,626.6
Numerator		19748	20387	20302	19426
Denominator		739588	733158	739599	739599
Data Source		MI STD Database	MI STD Database	MI STD Database	MI STD Database
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	2600	2600	2550	2500	2450

a. Last Year's Accomplishments

The Centers for Disease Control and Prevention, the National Preventive Health Task Force, and the National Center for Quality Assurance continue to support the science based recommendation for annual routine chlamydia (CT) screening for all sexually active females 24 and under. Cases and disease rates per 100,000 of chlamydia among 15-19 year old females in Michigan decreased slightly in 2011 compared to 2010 although 2011 remains higher than 2009 levels. It is too early to say if this decrease is indicative of decreased screening, or truly lower disease rates. MDCH Surveillance and Epidemiological staff will monitor this movement to see if a trend emerges.

In 2011 a total of 24,624 youth age 15-19 were screened in Michigan's publically funded sites. Just over 4,900 of these were screened in MDCH supported school-based and school-linked health centers (SB/SLHC); up considerably from just 3,809 in 2010. Much of this increase was generated via two school-wide screening events conducted in Detroit area schools. A total of 665 students were screened for chlamydia and gonorrhea during these events. Among those screened in 2011 in SB/SLHC, 15.7% tested positive for chlamydia. This reflects a slight decrease in positivity from 2010.

In 2011 fifty-eight SB/SLHC received support in the form of pre-paid tests for CT to screen those without other forms of payment. This was up from forty-nine in 2010. Of those found positive in these sites, 98% are treated in a timely manner, decreasing the rate of new infections.

The distribution and utilization of publicly supported CT screening resources is overseen by the Michigan Infertility Prevention Project Alliance (MIPP Alliance). Member of the Alliance include department staff from Adolescent Health, Family Planning, STDs, and the Bureau of Laboratories. Additional representatives attend from screening sites across the state. The Alliance meets quarterly.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Distribute CT screening resources to school-based/linked sites to increase access to screening.			X	
2. Monitor treatment completion and timeliness of those found				X

positive. At least 80% will be treated within 30 days.				
3. Distribute partner notification tools to 100% of school-based clinics to increase the number of partners notified of their exposure.				X
4. Utilize available data to target screening resources to those at highest risk for CT.				X
5. Actively participate in Michigan Infertility Prevention Project Alliance to gain information about CT in adolescents, and coordinate services with STD and Family Planning clinics.				X
6. Maintain = 10% positivity in school-based clinics through targeted application of publically funded screening resources.			X	
7. Facilitate 90-day re-testing of patients who are found infected to identify reinfection in a timely manner. This will be accomplished through education, provision of pre-paid tests, and educational materials.	X			
8. Provide STD medications to sites to cover treatment of uninsured patients.	X			
9. Partner with health systems and public schools in high incident communities to conduct school-wide screening events to increase access to CT screening.			X	
10.				

b. Current Activities

The CT screening project is an established program. Services remain rather stable from year to year with small adjustments. Current activities include:

•Distribution of pre-paid CT test requisitions
•Provision of medication for uninsured who test positive
•Education of providers on newest screening technology, and treatment guidelines
•Provision of partner notification tools to increase the number of partners informed of their exposure and treated
•Participation in Quarterly IPP Alliance meetings.
•Ongoing medical provider training on standards and guidelines associated with CT screening and treatment.
•Technical Assistance and provision of testing supplies to facilitate school-wide screening in high incident communities.

c. Plan for the Coming Year

Current screening patterns in SB/SLHC are expected to continue through 2013 as this will be the last year in the current CDC STD funding period, which supports a significant portion of the activities impacting this measure. Beginning in January 2014 a new funding period will begin, and to date there is a lack of clarity on what services will be eligible for support.

A number of national partners including the National Coalition of STD Directors, CDC--Division of Adolescent Sexual Health, and Advocates for Youth, a national advocacy organization, are interested in increasing access to screening for teens through school-wide screening. With this attention additional movement in this area may be seen in 2013. At the same time, these organizations are not able to provide any funding to directly support the costs associated with screening so the true impact of the advocacy of these organizations remains to be seen.

The Michigan IPP Alliance will continue to meet quarterly to share information, resources, and determine guidelines for resource distribution in the state.

State Performance Measure 7: *Percent of women physically abused during the 12 months prior to pregnancy*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					5
Annual Indicator		5.2	3.1	5.0	
Numerator		6276	3538	5672	
Denominator		121231	113090	113446	
Data Source		PRAMS	PRAMS	PRAMS	
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	4.9	4.9	4.8	4.8	4.8

Notes - 2011
Data collection is ongoing for 2011 PRAMS and data are not available to develop an estimate. Due to recent changes in population in Michigan and fluctuations in estimates due to PRAMS sample sizes, we could not develop a reasonable estimate for 2011.

Notes - 2010
Based on the 2012 Application submission, The numerator is for PRAMS and the denominator is the number of live births reported by vital records. We don't have 2009 PRAMS data to make further estimates so we can only calculate the expected number by using the number of live births reported by vital records for 2009 and 2010; hence the decision to use vital records live births as denominator and not the estimated number of live births from PRAMS.

The 2010 PRAMS data are still being weighted by CDC and are not available to the state at time of the 2013 Application submission to provide a final estimate.

Notes - 2009
For the 2012 submission, "The numerator is for PRAMS and teh denominator is the number of live births reported by vital records. We don't have 2009 PRAMS data to make further estimates so we can only calculate the expected number by using the number of live briths reported by vital records for 2009 and 2010; hence the decision to use vital records live births as denominator and not the estimated number of live births from PRAMS."

2009 PRAMS data were available for the 2013 Application submission so these numbers were updated.

a. Last Year's Accomplishments
Pregnant and postpartum women continued to be screened for family violence in the Maternal Infant Health Program (MIHP)throughout the past year . The questions used include: Do you feel safe in your current relationship? Have you been hit, kicked, slapped, or otherwise physically hurt by someone? By whom? How many times? Since you have been pregnant have you been hit, kicked, slapped, or otherwise physically hurt by someone? By whom? How many times? What part of your body? How did this person hurt you? Threats of abuse, including use of a weapon, slapping, pushing; no injuries and/or lasting pain, punching, kicking, bruises, cuts and/or continuing pain, beaten up, severe contusions, burns, broken bones, head, internal, and/or permanent injury, use of weapon, wound from weapon. Has your partner or someone else now in your life: called you names, humiliated you, or made you feel that you don't count? Kept you from seeing or talking to your family, friends, or other people? Thrown away or destroyed your belongings, threatened pets, or done other things to bully or scare you? Controlled your use of money, your access to money or your ability to work? Within the past year, has anyone forced

you to have sexual activities? Who was it? (Check all that apply) Current partner, Ex-partner, Stranger Others? How many times has this happened?
Standardized interventions to address domestic violence when a woman screens positive were used by nurse and social work professionals in the 120 MIHP agencies to provide consistent care coordination intervention.

Dialogue was initiated with state and local family violence prevention and treatment agencies in order to garner more resources for MIHP agencies to use. Contact with Futures Without Violence yielded training manual and videos which will be utilized in the required Fall 2012 Regional MIHP Coordinator Meetings. A relationship was also initiated with the Michigan Resource Center on Domestic and Sexual Violence to expand DV training resources and the Michigan Council Against Domestic and Sexual Violence to enhance advocacy activity.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. DV Screening at program entry for pregnant women with Medicaid insurance		X		
2. DV Screening at infant's birth for postpartum women with Medicaid insurance		X		
3. Provision of standardized DV care coordination interventions to all women who screen moderate and high risk for domestic violence		X		
4. Completion of standardized discharge documents that record risk at entry, highest interim risk, risk at summary and lists interventions provided during MIHP care		X		
5. Provision of web based training for MIHP professional staff			X	
6. Provision of face-to face training of MIHP Coordinators at Fall 2012 Coordinator meeting				X
7. Provision of resource information regarding domestic violence prevention and assistance throughout the state				X
8. Enhancement of relationships with statewide domestic and sexual violence organizations to improve resources for MIHP providers.				X
9.				
10.				

b. Current Activities
Family Violence training for all MIHP providers will be provided September 18-26, 2012 at the required MIHP Coordinator meeting. The meeting is held in four regional locations (SE Michigan, West Michigan, Northern Lower Peninsula and Upper Peninsula).
Presentation will include: brief intro to family violence and why we need to know about it in MIHP; 1st impressions video from CA Attorney General's office (addresses exposure to violence and a child's developing brain); PowerPoint from Futures Without Violence (selected material from modules 1-12) Video re how to use Future Without Violence tool (which we will pass out to all attendees); table top /regional discussion to list local resources. MIHP agencies will be given the link to the Michigan shelter finder http://www.mcadsv.org/help/locate.php

c. Plan for the Coming Year
Building on the evidence based maternal and infant risk identifiers, standardized interventions and both web and face-to face training provided for MIHP agencies around the issue of family

violence affecting pregnant women, activity in 2013 will focus on gathering and synthesizing discharge data regarding women who screened moderate or high risk for domestic violence. Risk level at screening, highest interim risk and risk level at summary will be entered into the state data base as well as documentation regarding standardized interventions were used to address the concern. Reports generated from this data and the associated analysis will assist the MIHP team as they move forward in addressing the effect of family violence on pregnant women and infants.

State Performance Measure 8: *Percent of high school students who experienced dating violence*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					3.3
Annual Indicator				15.0	15.0
Numerator				78775	78775
Denominator				525168	525168
Data Source				YRBS/Health People 2020	YRBS/HEALTH PEOPLE 2020
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	14	14	14	14	14

Notes - 2011
YRBS is the same data as previous year because the new data has not been released yet.

a. Last Year's Accomplishments
The Adolescent and School Health Unit within the Division of Family and Community Health partners with 25 Regional School Health Coordinators (at local Intermediate School Districts and Educational Service Agencies) throughout Michigan to train teachers to implement the Michigan Model for Health(r) curriculum for K-12 students. The curriculum includes age-appropriate lessons and skills building activities related to violence prevention and developing healthy and responsible relationships.

The Michigan Model has been placed on the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP), an online registry of mental health and substance abuse interventions that have been rigorously reviewed and rated by independent reviewers. While there are over 175 programs on the NREPP's list of evidence-based programs, the Michigan Model is the first comprehensive K-12 health education curriculum to be placed on this registry.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Recruitment and training of Teachers in the implementation of the Michigan Model for Health ® curriculum		X	X	

2. Promotion of Medicaid Services for eligible families.		X		
3. Evaluation of Michigan Model lessons.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Current activities include training teachers to implement the Michigan Model for Health(r) curriculum in grades K-12 and educate school-aged youth about the major health concerns for youth, including violence prevention and developing healthy and responsible relationships. Teachers implement the curriculum utilizing a variety of teaching tools, including books, videos, skills building activities, experts in the subject area, etc. Family and community involvement are also encouraged through the dissemination of Family Resource Sheets. These are sent home to the parents/guardians of the youth who receive Michigan Model for Health(r) lessons, such as violence prevention. The purpose is to educate parents/guardians and to encourage communication between students and their families.

In addition, families are educated about Medicaid--eligibility requirements, services, and application processes.

c. Plan for the Coming Year
The plan for FY 13 is to continue promoting the Michigan Model for Health(r) curriculum, increase the number of schools/teachers that implement the curriculum and reach more students as a result, and to secure funding to evaluate newly revised lessons within the curriculum. Increasing awareness of available Medicaid services for eligible families will continue as well.

State Performance Measure 9: *Percent of children receiving standardized screening for developmental or behavioral problems*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					18.2
Annual Indicator				18.2	18.2
Numerator				108524	108524
Denominator				596286	596286
Data Source				Nat'l Survey of Children's Health	State Estimate
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	18.2	20	25	30	30

Notes - 2011
The Medical Services Administration of DCH received a grant to improve billing for developmental screening. As yet, the data is not reliable enough to report for this indicator. Training of the provider network is ongoing.

a. Last Year's Accomplishments
Following the recommendations of the Michigan Perinatal Guidelines, a pilot NICU follow up project was developed. NICU follow up has two components to transition the high risk infant home. The first is a home visitation component and the second is follow up in an enhanced developmental assessment clinic (DAC). Infants that are eligible for follow up in the pilot include babies with birthweight of 1500 gms or less or gestational age of 30 6/7 weeks or less, babies that have had body cooling due to neonatal depression, babies with Down Syndrome and babies with neonatal Abstinence Syndrome. Infants are followed at 6 months, 12 months, 18 months and 24 months (adjusted) in the DAC. The pilot has DAC in three communities on a monthly basis. Infants in the DAC see the neurobehavioral pediatrician, nurse, as well as physical therapy, occupational therapy, speech and audiology, WIC and a psychologist. Infants are screened with the Bayley III. The three DAC were operational in March of 2011. Between 3/1/2011 and 5/31/2012 there were a total of 261 children seen and screened in Kent County, 107 in Ottawa County and 155 in Muskegon County.

Michigan's Maternal Infant Health Program (MIHP) has initiated the process to become evidenced based home visitation model including improving staff training, evaluation fidelity to model and assessing population outcomes using a quasi-experimental design. MIHP continues to provide care coordination home visitation services to pregnant women and infants with Medicaid insurance. Currently there are 120 MIHP agencies in all Michigan counties. Programs are housed in local health departments, tribal communities, FQHC's, hospital based clinics and in private agencies. Service is provided with a population management, care coordination approach. Focus in the past year has been on fidelity to model, certification enhancement, standardized documentation & research based data collection. Quality assurance measures have been enhanced in order to assure that services are consistently implemented in the varied programs throughout the state.

MIHP uses the Ages and Stages Questionnaire (ASQ)-3 and Ages and Stages Questionnaire -- Social Emotional (SE) with every MIHP infant beneficiary. The tool is scored and if results indicate a developmental concern exists, then the infant is referred to Early On for further evaluation and service. The parent is provided the original ASQ-3 or ASQ:SE screening document to assist the family in monitoring the growth and development of their baby.

MDCH continued to work closely with Part C (Early On), with a focus on improving developmental screening and subsequent referral to Part C by physicians. The Primary Care Developmental Screening project (PCDS) continues to train interested physicians to fully integrate developmental screening into their practice. Physicians (and other health professionals, such as MIHP providers) are trained to make referrals via the Early On central intake line/website. A referral form was developed that includes the needed referral information, consent for information sharing, as well as a section for disposition of the referral that Early On can fax back to the referring physician/provider.

Project LAUNCH continues to work with Michigan AAP to develop and pilot a Maintenance of Certification Quality Improvement project centered around developmental screening. Pediatricians that are due for renewal of their Certification can choose to establish a developmental screening project as their required QI project.

Expansion of developmental screening was a focus in the state's Race to the Top application; although not funded, the partners to that application remain committed to expand developmental screening for young children.

One means to accomplish that goal is through the Maternal, Infant and Early Childhood Home Visiting (MIECHV) system building efforts. Michigan's Benchmark's table has been approved; it includes several indicators related to developmental screening/monitoring. While these Benchmarks and measurements will initially apply only to MIECHV funded sites, they also lay an important foundation for expanding and enhancing home visiting services, including appropriate

developmental screening, for all home visiting programs in Michigan.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue implementation of the Perinatal Guidelines, Levels of Care recommendation for transition of NICU graduates through DAC and home visitation.				X
2. Movement of the Maternal Infant Health Program (MIHP) towards assuring all infant beneficiaries receive developmental screening using the ASQ-3 and ASQ:SE.		X		
3. Continue collaboration with Early On.	X	X		
4. Continue to work with MI AAP on MOC screening project.	X			X
5. Continue to implement PCDS project.	X	X	X	
6. Continue to convene the Developmental Screening workgroup.	X	X	X	
7. Explore means to establish more systematic data collection regarding developmental screening.				X
8.				
9.				
10.				

b. Current Activities
The pilot NICU follow up program continues in the three counties. Work on development of structure and process for home visitation is occurring using CSHCS and MIHP programs.

Trainings in Infant Mental Health and appropriate infant development have been taped by infant mental health experts and are now located on the MIHP website for professional staff to view. CEs are available for nurses and social workers . Efforts are in process to increase the developmental assessment and intervention competencies of MIHP professional staff including training and promoting endorsement as an Infant Mental Health Specialists. Standardized referral processes have been initiated for Early On which is intended to improve the referral rate.

Current activities include ongoing implementation of the PCDS physician training project, ongoing development of the MOC developmental screening QI project, implementation of developmental screening in home visiting, and cross-agency collaboration around developmental screening through the Developmental Screening workgroup of the Great Start System Team (ECCS).

c. Plan for the Coming Year
Continue with the NICU follow up pilot in western Michigan and expand to another region in Michigan if funding is available.

Plans are in development for training of MIHP Coordinators and MIHP professionals regarding medically fragile infants and infants with developmental delays. Increased screening using the ASQ-3 and ASQ:SE is anticipated as agency staff become more comfortable with the tools. Completion of the ASQ-3 and ASQ:SE has been identified as a critical indicator in the MIHP certification process-which essentially means a MIHP agency cannot be granted full certification if they are not consistently providing developmental screening to their infant beneficiaries.

An important next step is to enhance the state's ability to record and track data regarding developmental screenings. This is critical for coordinating efforts between medical home and

community services, and for avoiding duplication of screening efforts. Establishing an early childhood data system, linked to existing data systems and efforts across MDCH and other agencies, is a priority. Developmental screening data would need to be linked to the broader early childhood data system, and will be studied as a part of the effort to establish such a system.

State Performance Measure 10: *Proportion of the minority population served in publicly-funded health programs in relation to the general minority population*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					79
Annual Indicator				79.1	85.4
Numerator				753500	745199
Denominator				952301	873016
Data Source				Medicaid Database	Medicaid Database
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	80	81	82	83	83

a. Last Year's Accomplishments
The Kellogg Foundation extended their grant support to December 2013. During FY 2011, the Division of Family and Community Health and the Office of Health Disparities Reduction and Minority Health worked together to provide training to their staff and other interested persons from MDCH and local health on Undoing Racism by the People's Institute and on Health Equity and Social Justice by Dr. Renee Canady and Doak Bloss of Ingham County Health Department. This first year of training for the Bureau of Family, Maternal and Child Health staff focused on the Division of Family and Community Health which includes all of our MCH programs except WIC and CSHCS.

Three PRIME workgroups were formed to address evaluation, interventions and local collaboration. The Evaluation Workgroup developed a project evaluation plan, and completed an evaluation of the Undoing Racism training. The Interventions Workgroup identified national and local training models that address social justice and racism; assessed current staff training on relevant topics and began development of a green paper including a summary of the curriculum components and models related to their effectiveness on addressing outcomes in health disparities, and identification of potential toolkit components. The PRIME Intervention workgroup began discussing potential toolkit components in February 2011.

The goal of the PRIME green paper is to review strategies and theoretical approaches to guide the reduction of infant mortality. The outline for the PRIME green paper began in June 2011 and a draft was completed in September 2011. The PRIME green paper serves as a framework to develop an intervention for MDCH.

A Local Learning Collaborative (LLC) was established to share local work in undoing racism and health equity with other organizations and stakeholders throughout the state. The LLC includes 18 community partners. A main goal of the LLC is to develop a dissemination plan to share their work.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Kellogg Foundation Grant extended				X
2. Staff training on Undoing Racism and Health Equity & Social Justice				X
3. Organized Evaluation, Interventions and Local Collaborative work groups				X
4. Drafted green paper				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Finalize the Green Paper
Organizational assessment of WIC Division using a tool developed by the University of Michigan Multi-cultural Health
Trained local Maternal & Infant Health Program staff using Health Equity and Social Justice curriculum
MI selected to participate in the Partnership to Eliminate Disparities in Infant Mortality (PEDIM) Action Learning Collaborative, along with the 6 Healthy Start Projects in MI.
The Native American Ad-hoc Data Workgroup drafted a Native American specific PRAMS survey, adding questions on racism and social determinants of health to the survey. Implementation of the survey is expected to start this summer.
Finalize pilot curriculum components
Meet/consult with national leaders in infant mortality and health equity
Draft dissemination plan, including development of a website
The LLC prepared a pre-conference session at the 2011 Michigan Premier Public Health Conference. Additionally, the project contracted with 10 agencies on the LLC to gather information on the undoing racism and health equity work they have completed in their local communities.
The Intervention workgroup is continuing to develop the toolkit. The toolkit will contain resources regarding organizational assessment, workshops/trainings, ongoing training and ancillary activities (e.g., suggested documentaries).The toolkit will be used in conjunction with the PRIME Steering Committee model for reducing infant mortality.

c. Plan for the Coming Year

Training of WIC and CSHCS staff
Continue development of the toolkit
Complete Native American PRAMS survey
Revise curriculum
Continue participation in the PEDIM Alternative Learning Collaborative
Presentation on the PRIME project at the Michigan Premier Public Health Conference
Finalize and implement dissemination plan for the project

E. Health Status Indicators

#01A The percent of live births weighing less than 2,500 grams
#01B The percent of live singleton births weighing less than 2,500 grams

#02A The percent of live births weighing less than 1,500 grams
#02B The percent of live singleton births weighing less than 1,500 grams
Many factors contribute to the birth of low birth weight (LBW) infants. Babies with congenital anomalies or chromosomal abnormalities are often associated with low birth weights. Placental problems and maternal infections contribute to low birth weight infants. Additional maternal risk factors that may contribute to low birth weight include multiple pregnancies, previous low birth weight infants, poor nutrition, heart disease or hypertension, smoking, drug addiction, alcohol abuse, lead exposure and insufficient prenatal care. Low birth weight is more common in women less than 17 years and more than 35 years.
The percentage of low birth weight babies born in the previous five years has remained fairly consistently at 8.4% in Michigan. Very low birth weight babies (<1500 gm) account for 1.7% of births and moderately low birth weight (1500 -- 2500 gm) accounts for 6.7% of births. Low birth weight, along with prematurity, has remained the leading cause of infant death. Although LBW and prematurity affect less than one in ten infants, they increase an infant's odds of dying in the first year of life. The Michigan infant mortality rate among low birth weight infants is 26 times higher than normal weight infants and has decreased significantly in the past decade.
Of Michigan's 881 infant deaths in 2009, 150 (17%) were of a multiple gestation pregnancy. The infant mortality rate for singleton pregnancies was 6.5/1,000 for 2009 while the rate for multiple gestation pregnancies was 34.7/1,000 live births in 2009. Multiples represented 2.1% of all Michigan live births in 1980 and 3.7% of all Michigan live births in 2009. There has been a 42% increase in twin incidence over 20 years. The incidence of triplets and higher birth order has increased almost 300% over the last 20 years.
Population strategies in Michigan to reduce low birth weight births include alcohol prevention strategies through the Fetal Alcohol Syndrome Disorder program, Smoking Cessation program which supports a tobacco Quitline to help women reduce or stop smoking during pregnancy and home visitation programs to support women during pregnancy and complement provider prenatal care visits such as through the five Nurse Family Partnership programs (NFP) and through the Maternal Infant Health Program (MIHP). Four additional NFP sites will be started this year. In addition, strategies to reduce adolescent pregnancies, as well as family planning strategies to promote pregnancies that are planned and wanted continue to be strategies to reduce LBW births.
The governor has made infant mortality reduction a priority in the state of Michigan. An infant mortality Summit was held in October of 2011. Several strategies were identified that help to reduce low birth weight babies: improve preconception health, reduce unintended pregnancy, expand home visitation for at risk pregnant women, eliminate medically unnecessary deliveries prior to 39 weeks gestation, prevention of preterm deliveries through cervical length screening and progesterone treatment and restoration of the regional perinatal system and implementation of NICU follow up clinics. In addition, strategies to reduce the disparity in black/white birth outcomes remains a priority.

#05A. The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.
#05B. The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.
Data are from the Michigan Sexually Transmitted Diseases Database and are monitored by the Bureau of Epidemiology. For the period 2005-2011 case rates for females 15-19 first increased significantly and then decreased slightly in just the last year. Among 20-44 year olds rates have remained relatively low over time. Over 40% of the total chlamydia cases in 2011 were in Wayne County, including Detroit.
The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia in Michigan was 42.9 per 1000 in 2011. The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia in Michigan was13 per 1000 in 2011
The highest rates of chlamydia are found among the 15-19 and 20-24 year old age cohorts. The rates are highest among women in this age range, especially black women. The rate among black women is eight times higher than for white women. The overall rate among women is 2.6 times higher than in men, largely due to targeted screening towards females. Due to these data, females 15-24 are prioritized in resource allocation and screening guidelines. Additionally, to address the racial disparity, additional screening sites are identified and supported each year with

the expressed intention of screening young African American women who may not otherwise be screened.

Overtime, with consistent and broad screening of young women and their partners it is expected that the state will reach a "tipping point", where cases diagnosed and treated will outpace new infections. At that time case rates are projected to begin a consistent downward trend. 2011 marks the first year of decreased rates among our highest risk clients, females 15-19, this may be due to decreases in screening as a result of funding cuts to Family Planning and local STD programs, or may mark that we have reached that tipping point. Additional surveillance and time are required to determine which this down turn represents.
MDCH participates in the National Infertility Prevention Project (IPP) which targets adolescents and young adults (15-24 year olds). The IPP provides chlamydia screening in STD and family planning clinics, as well as school-based clinics, juvenile detention centers, and alternative adolescent sites, such as runaway shelters and alternative schools. Increased screening is encouraged as part of local health department reviews, Health Plan Employer Data and Information Set (HEDIS) reports, and IPP program evaluation.

The Child and Adolescent Health Center Program in Michigan conducts a Chlamydia/Gonorrhea screening project in 14 sites throughout the state. Each adolescent accessing the health center that identifies as sexually active receives a urine screen to test for both Chlamydia and Gonorrhea. In FY 11, over 4,000 urine screens were conducted, uncovering 512 positive cases of Chlamydia. This resulted in a 16% positivity for females and a 15% positivity for males. Eighty six percent of those positives were treated within 14 days.

Health Status Indicator #06 A & B
According to the U.S. Census Bureau, Michigan's population as of July 1, 2010 was 9,763,683, a decline of 3.2% since 2005. A declining birth rate and state economy contributed to the fall in the population level.

According to the 2010 US Census, 6.0% of Michigan's population was under 5 years of age; 26.8% of the population was under 20 years of age; 31.5% were 20-44 years; 27.9% were 45-64 years; and 13.8% were 65 years and older. From 2000 to 2010, the population under 20 years of age declined by 8.9%, and the population 45 years and older increased by 18.6%. Among the population under 20 years of age, 72.5% were white, 17.0% were Black, 0.7% were Native American, and 2.7% were Asian/Pacific Islander. The Hispanic population under 20 years of age was 6.3%.

Health Status Indicator #07A & B
Births in Michigan have declined since 2000 by 16%. The number of births to mothers in all age groups declined between 2000 and 2010, except births to mothers 40 years of age and over which increased 2.9%. White and black births declined between 2000 and 2011 (17% and 9.0%, respectively), while Native American and Hispanic births increased by 10.6% and 13.4%, respectively.

From 2000 to 2010, the birth rate decreased by 15% from 13.7 per 1000 in 2000 to 11.6 per 1000 in 2010. Nationally during this time frame, the birth rate decreased by 12%. From 2000 to 2010, the teen birth rate for teens 15-17 years of age decreased by 36% from 22.1 in 2000 to 14.1 in 2010. For 15-19 year olds, the rate decreased 19% during the same time period from 40.2 in 2000 to 32.4 in 2010.

From 2000 to 2010, the total number of live births to teens 15-17 years of age decreased by 36% from 4,607 in 2000 to 2,966 in 2010. For 15-19 year olds, the number decreased 23% during the same time period from 14,096 in 2000 to 10,832 in 2010.

In 2010, the birth distribution by race was 74% white, 19% black, 0.7% American Indian, 3/2% Asian & Pacific Islander and 2.6% all other races. The distribution by ancestry of the mother was

3.7% Arab and 7.1% Hispanic.

In 2010, teens 15-19 made up 9.4% of all births. White teens delivered 7.1 % of white births and black teens delivered 19.3% of black births, American Indian teens delivered 14.7% of American Indian births, Hispanic teens delivered 14.0% of Hispanic births.

Programs addressing unintended pregnancy and teen pregnancy in particular include the Michigan Abstinence Program, Teen Pregnancy Prevention Initiative, Taking Pride in Prevention, Title X Family Planning program, and the Child & Adolescent Health Center Program. Priority areas for teen pregnancy programming include reduction in the teen pregnancy rate in highest need populations in the state: City of Detroit, African-American youth and cities with more than 100 teen births in a year.

Health Status Indicator #08A & B
Michigan's Infant Mortality Rate has not changed significantly in the past 10 years and remains higher than the US rate. In 2000 the infant mortality rate in Michigan was 8.2 per 1000 as compared to the U.S rate of 6.9 per 1000. In 2008 the Michigan rate was 7.4 per 1000 and the U.S. rate was 6.5 per 1000. The infant mortality rate in Michigan in 2010 declined to 7.1 per 1000. Most infant deaths occur within the first 28 days of life. There were 817 deaths to infants 0 - 1 year old in 2010 out of a total of 2,135 deaths to infants and children 0 - 24. Infant deaths comprise 38.3% of all deaths to infants and children 0 - 24.

Disparities between the white infant mortality rate and the rates for other populations continues. Black infants died at 2.9 times the rate of white infants; Hispanic infants at 1.3 times the rate for whites; and American Indian infants at 1.9 times the white rate. A three year average of infant mortality rates for 2007-2009 for black infants was 15.5 per 1000, Hispanic infants 9.1 per 1000, Native American infants 9.3 per 1000, and Arab infants 7.4 per 1000 compared to the white infant mortality rate in the same time period of 5.5 per 1000. In 2010, the demographic data for infant and child deaths by race for ages 0 - 24 are 61.3% white, 33.5% black or African American, 0.9% American Indian or Native Alaskan, 1.4% Asian. Total deaths of infants and children aged 0 - 24 enumerated by ethnicity is 6.5%.

From 1999-2009 the infant mortality rate among Blacks decreased by 9.1% and among Whites the rate declined 6.8%. Neither change was statistically significant. Changes in how race is categorized may account for some of the fluctuation seen.
The infant mortality rate is significantly higher among younger women than among women ages 20 -- 39. There has been no significant change in the past ten years. Except for the youngest mothers (<15 years of age), the high incidence of infant mortality among women less than 20 years is attributed to lower socio-economic status, little or no prenatal care and lack of social support.

The leading causes of death for infants under age 1 in 2010 were disorders relating to short gestation and unspecified low birthweight, congenital malformations, accidents, SIDS and maternal complications of pregnancy.

Recognizing that infant mortality is a public health problem, the governor has made infant mortality a priority strategy in the state of Michigan. An infant mortality Summit was held in October of 2011. Stakeholders gave input and priority strategies were identified: 1) improve preconception health, 2) improve reproductive planning and intended pregnancy, 3) promote home visitation services through the Maternal Infant Health Program, Nurse Family Partnership, 4) eliminate medically unnecessary deliveries prior to 39 weeks gestation, 5) prevention of preterm deliveries through cervical length screening and progesterone treatment 6) restoration of the regional perinatal system, 7) implementation of NICU follow up clinics, 8) breastfeeding promotion and 9) reduce the disparity in black/white birth outcomes. These strategies were selected because of the nature of their impact on the infant mortality problem. The department is working to implement the strategies with available resources. Currently there are limited funds

allocated for the strategies

State and national data indicate that accidental infant suffocation/strangulation deaths caused by unsafe sleep environments continue to be a leading cause of infant death, especially for African-American and American Indian infants. MDCH will continue to pursue and support the development of effective programs and messaging in an effort to promote safer infant sleeping practices and prevent suffocation/strangulation for Michigan infants. Statewide delivery of strong messages will be supported through collaboration with birthing hospitals, child care providers, home visiting programs, pediatric practitioners and community-based organizations.

The leading causes of death among children ages 1-14 were accidents, cancer, homicide, congenital malformations, and heart diseases. Since 2003, deaths among children ages 1-4 years due to accidents declined by 28%, due to homicide declined by 20%, and due to congenital malformations declined by 22%. For children ages 5-14, accidental deaths declined by 49%. Deaths due to cancer, congenital malformations and homicide remained at about the same rates. Disease of the heart replaced pneumonia as the fifth leading cause of death among 1-4 year-olds, and suicide as the fifth leading cause of death among 5-14 year-olds. Accidents was the leading cause of death for both black and white children ages 1-14.

For ages 15-24, the leading causes of death were accidents, homicide, suicide, cancer and heart diseases. Since 2003, accidental deaths for this age group declined by 12%, and deaths due to diseases of the heart declined by 21%. Homicide deaths increased by 25%, and suicide deaths increased by 10%. The rate of cancer deaths remained the same. For white children ages 15-24, the leading cause of death was accidents. The leading cause of death for black males was homicide, and, for black females, was septicemia.

Health Status Indicators #11 and 12
According to the 2010 American Community Survey, 16.8% of the total population was below the federal poverty level, and 23.5% of children under 18 were below poverty level. Overall, the three-year average poverty level in Michigan increased from 10.3% for 2000-2002 to 15.4% for 2008-2010. Child poverty in Michigan is up 64% from 2000 to 2009, compared to the 18% increase in the national child poverty rate over the same period, according to the Kids Count Data. In 2010, 12.1% of all families and 33.8% of families with a female householder and no husband present had incomes below poverty.

The poverty data reflects the economic circumstances in Michigan over the past few years. The average annual jobless rate rose from 5.2% in 2001 to 10.3% in 2011, peaking in 2009 at 13.4%. As of April 2012, the jobless rate stands at 8.3%, demonstrating the slow economic recovery in the state. Between 2008 and 2010, the median income of households in Michigan was $46,861, down 5.7% from the 2006-2008 period. During FY2011, on average approximately 26% of the state's population received some form of public assistance.

F. Other Program Activities

The Count Your Smiles (CYS) survey was designed to address dental outcomes in Michigan that pertain to those HP2010 objectives. In addition, CYS will contribute to Michigan's oral health surveillance system. The purpose of the program is to spotlight oral disease prevalence in third grade children and address oral health disparities among children for both dental disease and access to dental care. The report also determines the use of sealants and community water fluoridation. The survey followed the format of the Basic Screening Survey, a national survey developed by the Association of State and Territorial Dental Directors. The Count Your Smiles was conducted in fall 2005 to determine sealant placement rates and oral disease prevalence in third grade children in Michigan. A statistical sampling included 76 elementary schools and approximately 1586 children participated in the program.
/2012/ The Count Your Smiles (CYS) survey was completed in 2010 and the data collected and

reviewed the oral health epidemiologist. A final report regarding the results was drafted. Plans are to finalize and publish the CYS survey report, and disseminate it to external and internal stakeholders for further advocacy work to expand the school-based sealant program. //2012//

The Michigan Department of Community Health Oral health program and Department of Environmental Quality (Water) collaborate to promote community water fluoridation. This collaboration has proven success as demonstrated by the reestablishment of community water fluoridation in additional 3 communities within the state. MDCH utilized the data from the Count Your Smiles of 3rd grade children in Michigan to gain administrative support to develop a state-wide dental sealant program for 2nd grade high risk children.

The second Count Your Smiles 2009-2010 started in September 2009. The survey was planned to wrap up by 30th April 2010 but, due to increased recognition of the program, the time line is extended as more schools are interested in taking part in the survey. The purpose of the survey is similar to the previous survey conducted in 2005-2006, but now also focuses on issues such as the effect of dental insurance in obtaining dental treatment, and ethnicity-related oral disease prevalence and the occurrence rate. The statistical sample this time includes 78 schools with 1,989 children to date, expecting a few more schools to participate in the program.
/2013/ The Count Your Smiles Survey was published in 2011 and demonstrated the need for continued advocacy on the implementation of dental prevention programs. The oral health findings were published in the Kids Count in Michigan Databook 2011 published by the Michigan League of Human Services. The information also provides support for earlier interventions from infancy through age five in developing an infant oral health program for medical providers and other early childhood organizations. //2013//

1-800-26-BIRTH is staffed by health or social service professionals to answer both information as well as calls of pregnant women and parents. The staff are updated, quarterly, on the availability of services, eligibility requirements, and contact persons for local prenatal care and WIC providers and assist the client in identifying these and other providers in the client's community. Counselors are trained to respond to a broad range of health care needs. The hotline is marketed by local and state agencies through pamphlets, posters and public service announcements. Several times a year a flyer describing this service is mailed with every Medicaid identification card to each recipient and in AFDC warrants. In FY 2009, 6,771 calls were handled by the hotline, not including 194 wrong number calls and 861 undetermined calls.
/2012/ In 2009 the hotline served 9,215 clients. //2012//
/2012/ In FY 2010, 11,653 calls were handled by the hotline. Included in the total were 213 wrong number calls and 1,041 calls that were undetermined. //2012//
/2012/ Effective October 1, 2011, the MCH hotline will be managed by Michigan 2-1-1, a United Way of Michigan operation. The statewide service is operated via eight regional locations that specialize in providing health and human services information via the phone or web, using a regularly updated data base specific for the coverage area. The regional offices operate with trained call specialists and under the umbrella of the state 211 coordinating office. //2012//
/2013/ For FY 2010-2011 there were 10,408 women and infants served by the program. Michigan has used the MI Healthy Babies to promote the 2-1-1 as a community services resource for prenatal women and parents. We are making a transition to 2-1-1 in entirity and a mobile smart phone site has been developed to promote either telephone or web access for community services information and assistance. We envision at some future date the 1-800-26Birth number may be phased out. 1-800-26Birth has not been phased out for WIC. WIC is using the number in current promotion. //2013//

Promising Practices for Reducing Racial Disparities in Infant Mortality in Michigan (WKKF Grant) -- The Department has received a grant from the Kellogg Foundation to develop a model curriculum and tool-kit that MDCH and local/state health departments may use to address disparities in health outcomes. The tool-kit will include strategies and tools to promote continuous quality improvement, collaboration and accountability, and public sharing of measurable outcomes that reflect racial and health equity. The project goals are to identify and eliminate

institutionalized discriminatory policies and practices in MDCH MCH and to focus more of MCH funding, policy and practice on monitoring and addressing social determinants of racial disparities in infant mortality.
/2013/ The project is now called PRIME (Practices to Reduce Infant Mortality through Equity). In December, 2010, the Kellogg Foundation granted an additional 3 years of funding for the project. A steering team has been established to provide leadership and guidance to the overall goals, objectives, and evaluation of the project. A Project Coordinator was hired in September 2010. Between March-May 2011, 170 staff from MCH and the Division of Health Wellness and Disease Control, along with members of PRIME, attended a two-day Undoing Racism Workshop facilitated by the People's Institute for Survival and Beyond. In addition, state staff received training in the Health Equity and Social Justice curriculum developed by Ingham County Health Department in the Fall of 2011. //2013//

/2012/ MDCH was awarded a grant "MI Healthy Baby" for the period of Sept. 1, 2010 -- Aug. 31, 2013. The goal of this project is to raise the awareness of women, men, and expectant parents about the need for preconception, prenatal and interconception care; and provision of resources for information on parenting and family support utilizing traditional and electronic media. The grant will help MDCH address high rates of preterm birth, low birth weight and racial disparities which contribute to infant deaths by using traditional and electronic media to engage and link the intended population to community resources.//2012//
/2013/ The HRSA grant funding was eliminated for the third year of the MI Healthy Baby project, and now ends on Aug. 31, 2012. //2013//

G. Technical Assistance
At this time, we have no requests for technical assistance. Staff development efforts will be focused on the PRIME project for the next year and a half. Technical assistance for that project (funded by the Kellogg Foundation) is obtained through the University of Michigan, the University of North Carolina and the Michigan Inter-tribal Council. Limitations on staff resources preclude additional activities for the present time.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	19039800	17516240	17717800		18019600	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	34492500	44666430	36924100		45270000	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	1000000	627372	996800		996800	
6. Program Income *(Line6, Form 2)*	63054900	57576129	63651900		63943100	
7. Subtotal	117587200	120386171	119290600		128229500	
8. Other Federal Funds *(Line10, Form 2)*	361244156	315074953	362502868		378618492	
9. Total *(Line11, Form 2)*	478831356	435461124	481793468		506847992	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	0	0	0		0	
b. Infants < 1 year old	63054900	57576129	63651900		63943100	

c. Children 1 to 22 years old	8453700	8086418	8183600		8453700	
d. Children with Special Healthcare Needs	41988500	50865011	44446400		53155800	
e. Others	3895500	3694825	2833400		2509900	
f. Administration	194600	163788	175300		167000	
g. SUBTOTAL	117587200	120386171	119290600		128229500	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		97260		100000	
c. CISS	140000		132000		150000	
d. Abstinence Education	0		3407813		3377694	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	206159200		190396811		198448737	
h. AIDS	1212495		1212495		1212495	
i. CDC	1799117		1806021		897730	
j. Education	0		0		0	
k. Home Visiting	0		0		5814126	
k. Other						
HRSA	300000		300000		270000	
Preventive Block	416600		416600		416600	
Title X	7133200		7950768		7627610	
Title XIX	143988900		156783100		160303500	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		**FY 2012**		**FY 2013**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	52739800	61877544	54092500		62522100	
II. Enabling Services	58645100	52593775	58688200		58644500	
III. Population-Based Services	6007700	5751064	6334600		6895900	
IV. Infrastructure Building Services	194600	163788	175300		167000	
V. Federal-State Title V Block Grant Partnership Total	117587200	120386171	119290600		128229500	

A. Expenditures

Expenditures for FY 2009 reflect changes in federal and state appropriation amounts. On Form 3, Line 5, the difference between the budgeted amount for FY2009 and the expenditures is due to decreased donations to the Children's Special Health Care Fund. The decreased amount in federal funding (Form 3, line 1) is the actual final Title V allocation.

On Form 4, the difference between 2009 budget and expenditures for "Others" represents the cut in state funds to family planning and pregnancy prevention programs. The difference in Line I.f. between budget and expenditures is the elimination of invoice processing charges for CSHCS (also shown on Form 5, Line IV).

In a unique situation, expenditures in the CSHCS program were significantly higher than the budgeted figure due to one complicated hemophilia case (Form 3, line 3; Form 4, line I.d; Form 5, line I).

/2012/On Form 3, Line 2, the difference between budgeted and expended is due to funding shifts between federal and state sources as a result of the change in the federal match rate under ARRA. This effect is also evident on Form 4, Line I.d. On Form 3, Line 5, the difference between the budgeted amount for FY2009 and the expenditures is due to decreased donations to the Children's Special Health Care Fund. The decreased amount in federal funding (Form 3, line 1) is the actual final Title V allocation.

On Form 4, the difference between budgeted and expended funds on Line I.e "Others" reflects the cuts in state funds for Family Planning and Pregnancy prevention programs. The difference between budgeted and expended funds for Infrastructure Building on Form 5 is due to the elimination of invoice processing charges for the CSHCN program.//2012//

/2013/The difference between budgeted and expenditure figures for 2011 reflect the shift of funding sources from ARRA federal funds to state funding (Form 3, line 3; Form 4, line I.d; and Form 5, line I); and the re-negotiation of the WIC formula rebate agreement (Form 3, line 6; Form 4, line I.b, and Form 5, line II).//2013//

B. Budget

The maintenance of effort level from 1989 is $13,507,900. This amount represented state funding for Children with Special Health Care Needs, Family Planning, Adolescent Health, Local MCH and WIC. Current MOE level is maintained by expenditures for CSHCS.

The projected match for FY 2011 is $34,492,500. In addition to state general funds, the federal-state partnership includes program income from the WIC and newborn screening programs and Children's Trust Fund monies supporting CSHCN.

Other funding sources that support MCH programs include Title X (Family Planning), WIC, Medicaid and grants from other federal and foundation sources.

The change in budgeted funds from 2010 to 2011 reflects an increase in Program Income for Newborn Screening fees and WIC Rebate (Form 3, line 6; Form 4, line I.b; Form 5, lines I and III), cuts in state funding for Family Planning and Pregnancy Prevention (Form 3, line 3; Form 4, line I.e; Form 5, line I), and elimination of invoice processing charges for CSHCS (Form 3, line 3; Form 4, line I.f; Form 5, line IV).

/2012/Budgeted figures for the federal Title V allocation on Form 3 for FY 2012 reflect the authorized spending level, as opposed to the final grant award. There were no other significant differences between FY 2011 and FY 2012 budgeted figures.The other line items are based on

best estimates of the state and federal resources that will be appropriated to us.//2012//

/2013/ Budgeted figures for 2013 reflect funding levels authorized by the State at this point. Funding levels were generally steady from 2012 to 2013 except for pregnancy prevention programs. State funding cuts for this program can be seen on Form 4, line I.e ("Others").//2013//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.